

**Psychological formulation in residential teams working  
with people with dementia: An exploration of  
multidisciplinary views using  
Q-methodology.**

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## THESIS ABSTRACT

Psychologists are encouraged to integrate their practice more closely within multidisciplinary mental health teams, whilst maintaining their professional identity (Onyett, 2007). The Team Formulation approach is one solution; this aims to provide a protected thinking space for a group staff to construct a shared understanding of a service user's difficulties which guides intervention planning (Johnstone, 2014). However, it requires some initial investment from services.

Chapter one investigated the evidence relating to the use and effects of team formulation in secondary mental healthcare. Eleven papers were systematically critiqued. A synthesis of findings revealed that whilst team formulations had no direct impact on clinical outcomes, they helped promote psychological thinking and facilitated better working alliances with service users. Several quantitative studies minimised bias through control groups and randomised designs, although practice-based evidence may have overstated effects due to a lack of methodological rigour. To address the identified gaps and limitations of the literature, chapter two describes a Q methodology study exploring multidisciplinary views on formulating with teams in dementia care settings. Participants ranked the relative importance of various aspects of sessions, and elaborated on their views through a semi-structured interview. Results indicated three shared viewpoints regarding what was most valued about a team formulation approach, namely: *Working together to identify residents' unmet needs*; *Prioritising the needs of the resident versus those of the team*; and *Being heard – Valuing the relationship between the facilitating clinician and team*. Viewpoints were explored in terms of their implications for clinical practice, including supporting residential teams to process the emotional impact of their work in addition to maintaining a focus on residents' individual needs. Finally, chapter three provides a first person reflective account of the process of completing this thesis, and its impact on the personal and professional development of the author.

Total word count: 18,993 (excluding references and appendices)

## PREFACE

The first chapter of this thesis will be submitted to the *British Journal of Psychology*, and the second chapter will be submitted to *Dementia: The International Journal of Social Research and Practice*.

Each chapter has been written in accordance with the author guidelines provided by the respective journal (Appendices W & X), with three exceptions:

- Tables and figures are included within the main text where appropriate, to improve readability of the thesis.
- Chapters have been formatted according to Staffordshire and Keele Universities' guidelines for the submission of professional theses.
- The literature review (Chapter 2) has been written within the word limit specified in personal communication with the Co-editor of *Dementia* (Appendix Y).

The third chapter of this thesis offers a reflective commentary of the research process that is not intended for publication; it assumes readers are familiar with the preceding chapters.

## **Chapter 1: Literature Review**

### **The Impact of Team Formulation in Secondary Mental Health Services: A Literature Review**

## **ABSTRACT**

The aim of this review is to describe and evaluate the current evidence base relating to the impact of team formulation in mental health settings, whereby a discrete session brings multidisciplinary staff together to develop a shared understanding of a service user's difficulties (Johnstone, 2014). A systematic search was undertaken to identify literature published since 2007. Of the 466 papers identified, 11 of mixed methodologies met inclusion criteria. These were critically appraised for methodological quality, and findings synthesised using thematic analysis. Papers ranged from rigorous qualitative and randomised designs, to practice-based evidence of lesser methodological quality. Four themes were identified regarding the effects of team formulation, including (1) relating better to service users, (2) lack of direct benefit to service users, (3) benefitting staff, and (4) effects on the organisation. Though not linked with directly reducing service users' distress, results highlighted the supportive role that team formulation has in promoting psychological thinking and insight within the service, individualising care plans, and developing stronger working alliances with service users. These findings resemble those relating to the use of formulation in individual psychotherapy. Clinical implications and limitations of the review are discussed, in addition to recommendations for future research.

Abstract word count: 197/ 200

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## INTRODUCTION

In the early stages of structured psychotherapy, the therapist seeks to develop an explanatory account of an individual's mental health difficulties by summarising and integrating the information gathered at assessment (Johnstone & Dallos, 2006). The process by which this is achieved is referred to as formulation, also known as case conceptualisation. Formulation involves drawing on psychological theory and research to generate hypotheses about how a client has come to experience their emotional, behavioural, and/or interpersonal problems at a specific point in time (Division of Clinical Psychology (DCP), 2011). Depending on the clinician's therapeutic background and preference, s/he will take a different view of the most relevant factors (e.g. thoughts, feelings, social circumstances) and explanatory concepts (e.g. core beliefs, unconscious conflicts, narratives) to focus on when developing a formulation of the client's problems. Regardless of differences owing to diverse therapeutic models, all formulations essentially use psychological concepts to summarise the individual's difficulties, demonstrate how these problems relate to one another, and provide an account of how these problems have developed and are maintained. Thereafter the formulation is used to indicate appropriate interventions, guide treatment, and is open to revision and reformulation as new information emerges (Johnstone & Dallos, 2006).

### *Formulation in individual therapy*

Despite the emphasis placed on the development of the formulation in individual therapy, the research concerning its efficacy is relatively sparse, with most studies focusing on the reliability of case formulations (for a review see Flinn, Braham & das Nair, 2015). Aston's (2009) review of cognitive-behaviour therapy literature concluded that clients are ambivalent about whether they find the formulation process useful. The evidence that formulation enhances therapeutic outcomes is weak (Bieling & Kuyken, 2003); several studies have failed to report a benefit over manualised therapy approaches (Emmelkamp, Bouman & Blaauw, 1994; Schulte, Kunzel, Pepping & Schulte-Bahrenburg, 1992), although there is some evidence that clients engaged in individualised therapy approaches are more likely to sustain clinical gains in the long term (Jacobson et al., 1989).

However, developing a shared understanding of the presenting issues through via the formulation may act as a vehicle for other inter-/intra-personal processes important to helping the individual move forward; these include strengthening the working alliance between therapist and client, and nurturing a sense of hope and self-efficacy (Aston, 2009; Redhead, Johnstone & Nightingale, 2015). Furthermore, standardised treatments alone are unlikely to be appropriate for clients with complex biopsychosocial needs, such as secondary mental health service users (Haynes & Williams, 2003).

### *Formulating in mental health teams*

Secondary mental health services provide specialist assessment and intervention to individuals in the community experiencing severe and enduring mental health problems, whose needs are best met through a coordinated multidisciplinary approach (Joint Commissioning Panel for Mental Health (JCPMH), 2013). The publication 'Mental Health: New Ways of Working for Everyone' (NWW; Department of Health (DoH), 2007) outlined the need for mental health teams to develop effective working practices to ensure that professionals are coming together to provide a quality and sustainable service to individuals in need of specialist mental health care. At this time Onyett (2007) argued that psychologists needed to become better integrated into the interdisciplinary work of mental health teams, whilst also maintaining their unique professional identity such as formulating from multiple perspectives (DCP, 2010). Relative to other professional groups, clinical psychologists are underrepresented within mental health teams and therefore regarded as a limited resource (Roe, Yanos & Lysaker, 2006). Providing formulation-led consultation to colleagues in relation to their clinical work potentially represents an efficient use of clinical psychology resources, whilst also promoting service users' indirect access psychologically-informed care (Onyett, 2007; Lake, 2008).

Using formulation in teams is recommended practice by psychologists' professional (DCP, 2011) and regulatory bodies (Health and Care Professions Council (HCPC), 2015). A variety of approaches to formulation-led consultation have been taken with community and inpatient mental health teams to date,



although the evidence-base for these is limited to a small number of qualitative studies and service evaluations.

Hewitt (2008) describes a clinical case example, during which an initial integrative formulation of a female service user's emotional and behavioural self-regulation problems was presented to the staff team. Subsequently the team were engaged in a process of reformulation and intervention planning, which reportedly led to an improved working relationship between the clinical and ward teams. Staff also reported having developed insight and empathy regarding the service user's difficulties, countering feelings of despair by highlighting the progress made by and with her.

In a community service, Christofides, Johnstone and Musa (2012) found that clinical psychologists tended to share formulations informally in multidisciplinary teamwork through 'chipping in' ideas and hypotheses during existing forums. Psychologist participants felt this contribution helped staff members make sense of their work with service users, and promoted a more cohesive team approach to intervention. Themes also highlighted the importance of recognising the experience of staff and avoiding the 'expert position' when offering an opinion, in an attempt to subtly introduce alternative, psychological perspectives. This was reportedly valued by multidisciplinary staff in the same team during a follow-up study, who expressed a desire for more formulation work with the team given it's perceived benefits in terms of increasing staff cohesion, improving team dynamics, and offering an alternative perspective to the dominant biomedical model of distress (Hood, Johnstone & Christofides, 2013).

### *Team formulation*

In contrast to the more directive and informal approaches noted above, the Team Formulation approach aims to provide a protected thinking space for a group or team of professional and non-qualified staff to construct a shared understanding of a service user's difficulties (Johnstone, 2014; Lake, 2008). Team formulation thus involves a discrete session focused on developing the formulation, and draws on the skills and experiences of the whole team throughout this process.

Having introduced team formulation sessions within functional and organic inpatient services for older adults, Dexter-Smith (2007, 2010) provides reflective accounts at two time points. She reports having noticed staff demonstrating greater skill in hypothesising about service users' cognitive and emotional experiences post-formulation, in addition to providing more focussed interventions. However, the acceptability of the team formulation approach was seen to be threatened by practical challenges within an already busy environment, namely the time and staff attendance commitments. Summers (2006) interviewed staff working on a high-dependency ward regarding their views on the impact of team formulation sessions. Sessions involved collaboratively reviewing the service users' history and staff members' experiences of the service user to develop the formulation using cognitive-behavioural and/or dynamic concepts. Whilst some participants felt that this new understanding needed to guide care plans to a greater extent, overall findings supported the previously cited benefits (Christofides et al., 2012; Hewitt, 2008; Hood et al., 2013).

### **Rationale for the Current Review**

Services look to find new and efficient ways of improving the provision of effective multidisciplinary mental health care (DoH, 2007), which is personalised to the individual needs of the service user (JCPMH, 2013; National Institute for Health and Care Excellence (NICE), 2009, 2014, 2016). As outlined above, the use of psychological formulation in teams is becoming an increasingly popular method of developing shared person-centred conceptualisations and guiding interventions for service users across a variety of community and inpatient settings. However, individualised approaches to intervention are more resource-intensive than standardised mental health treatments in the short term.

In order to make informed decisions regarding the allocation of scarce resources within the sector, there is a need to systematically identify and evaluate further literature regarding the use, processes, costs and benefits of team formulation in mental health services. Specifically, at this stage an exploration of the effectiveness and outcomes of team formulation is warranted, as the status of the evidence base is currently unclear (DCP, 2011; Johnstone, 2014).

**Aim**

This review aims to explore and critically appraise the literature relating to the use of team formulation in mental health services. It focuses on providing a synthesis of the reported outcomes of team formulation since the release of the NWW guidance for mental health professionals (DoH, 2007), in terms of the range and nature of effects.

## **METHOD**

### **Search Strategy and Selection Criteria**

In order to search for papers related to what is currently known about team formulation sessions and their impact in mental health settings, a systematic approach to identifying and reviewing relevant literature was taken. Electronic databases were searched for content up until 12<sup>th</sup> October 2015. The terms 'Formulation', 'Team', 'Mental health', and 'Impact' were combined using a variety of operators and synonyms across databases (see Appendix A).

The meta-search engine EBSCOhost was used to search the databases Academic Search Complete, AgeLine, The Allied and Complimentary Medicine Database (AMED), CINAHL Plus with Full Text, MEDLINE, PsychARTICLES, and PsychINFO. Further searches were also completed using Web of Science Core Collection and the Cochrane Library. Results were limited to academic journals and dissertations in the English language published since 2007 (i.e. post-NWW). In an effort to counteract publication bias, grey literature sources such as unpublished studies and doctoral theses were also sought through the British Library E-Theses Online Service (EThOS). To obtain a comprehensive picture of the literature as it relates to the review question, relevant practice-based evidence (including service evaluations) was also considered. Hand searching of eligible articles' citations (using Google Scholar), reference lists, and authors' other publications was also undertaken. It was unclear whether two studies met the review criteria (as below) as the authors had not included sufficiently detailed information regarding participants; the authors were contacted for further information, which when provided excluded the studies in question.

All articles were assessed against the current review's inclusion and exclusion criteria prior to inclusion in the final selection.

### ***Inclusion Criteria***

Papers that met the following criteria were considered for review:

- Intervention and Setting - A team formulation meeting had taken place within the context of a secondary mental health service. Team formulation

meetings were defined as discrete sessions during which multiple members of a team (i.e. >2) contributed to developing a shared psychological understanding of the development and maintenance of a service user's difficulties, and/or team members' working relationship with the service user (Johnstone, 2014). Secondary mental health services were defined as acute inpatient wards and community mental health teams working with a range of service users including children and young people, adults, older adults, and people with an intellectual disability.

- Population - Clinical/care staff who have attended a team formulation session were the primary or secondary participants. This constituted qualified and non-professional staff employed in the capacity of providing care, support, rehabilitation, or treatment to service users experiencing mental distress.
- Outcome - The impact of team formulation was identified through quantitative or qualitative data collection methods. Due to the current paucity of literature investigating the effects of a team formulation approach, the current review was interested in the diversity of reported outcomes linked with the provision of team formulation. Therefore, 'impact' was defined as the effect of the team formulation, which may be manifested through participants' subjective experiences, views, and/or objective outcome measures related to the meeting.

### ***Exclusion Criteria***

Papers meeting any of the following criteria were excluded:

- Opinion papers and commentaries on practice that did not present findings drawn from a sample of participants. For example, papers that do not present evidence collected through a research or evaluation methodology.
- Failure to meet the aforementioned definition of team formulation. For instance, studies in which the formulation was didactically presented to the team as an expert opinion or observation, rather than having been developed collaboratively with the team.

The majority of papers identified did not meet the inclusion criteria, and were therefore excluded. If unclear from the title and abstract, full texts were examined for eligibility. The results of this process are depicted below (Figure 1).

### **Critical Appraisal**

In order to provide a critical appraisal of the papers included in this review, two sets of questions were developed as no single tool addressed the various methodologies used. For quantitative studies, 11 key questions (comprising 24 items; Appendix B) were derived from the Randomised Controlled Trials Checklist (Critical Appraisal Skills Programme (CASP), 2013a), Downs and Black's (1998) checklist for critically appraising randomised and non-randomised studies, and guidance provided by Young and Solomon (2009). The Qualitative Research Checklist (CASP, 2013b) and guidelines for appraising qualitative research (Elliott, Fischer & Rennie, 1999) informed nine key questions (comprising 18 items; Appendix C) for qualitative studies. Mixed methods studies were subjected to the relevant items of each checklist.

The reviewer established the quality of the included papers by scoring the appropriate set of appraisal questions: one point was allocated for items that could be answered affirmatively, half a point for items where the quality assessment question was addressed to an extent but not completely, and nil points for items answered negatively or where the study lacked sufficient information to make a judgement (Appendices D & E). Subsequently the reviewer divided the total quality score by the number of applicable items to that study, yielding a percentage reflecting the extent to which each paper satisfied the critical appraisal tool.

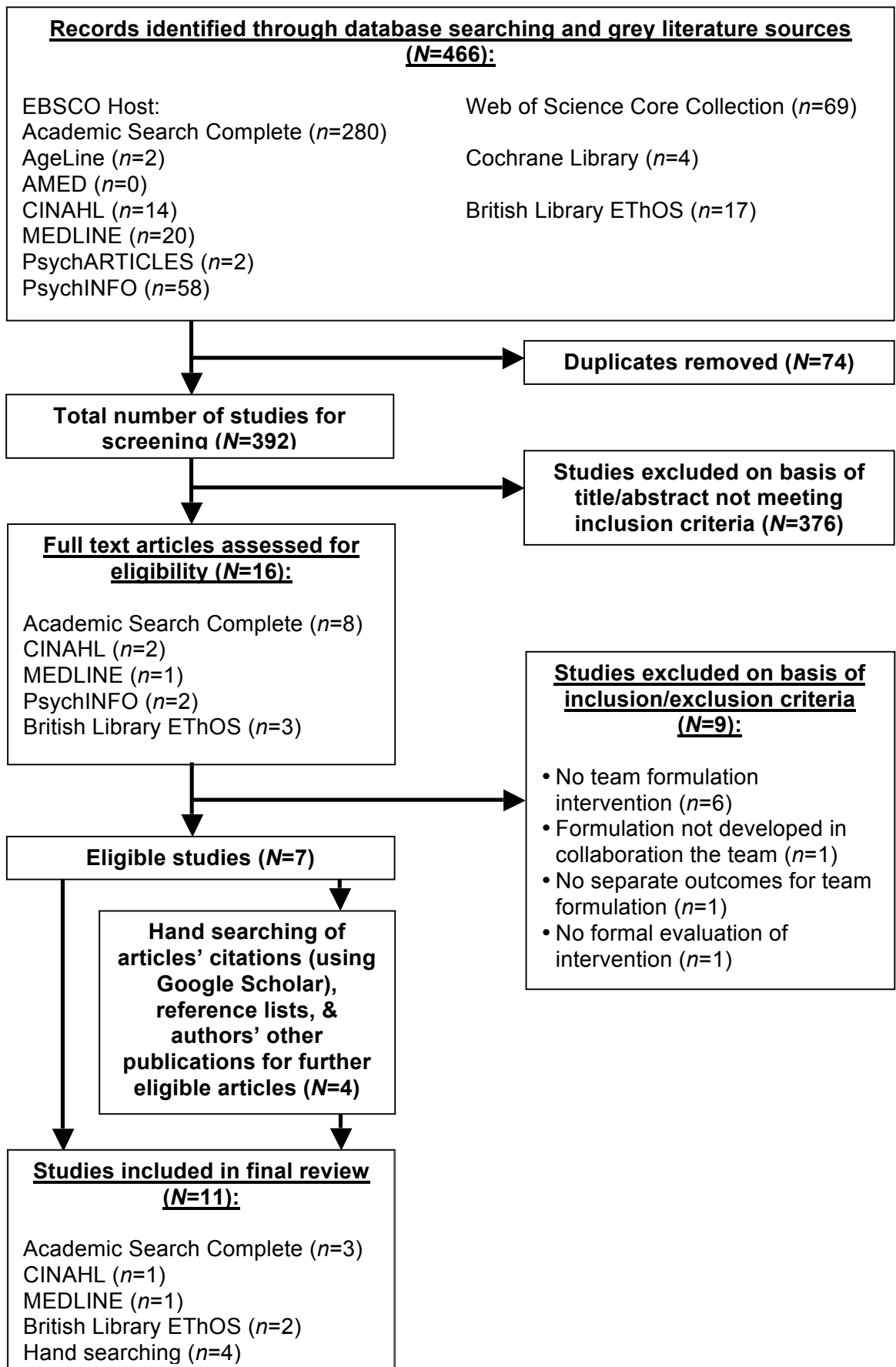


Figure 1. Literature review screening process flowchart.

## RESULTS

The literature search retrieved a total of 11 articles that met the inclusion criteria, of which: five papers used qualitative methods (Table 1.1), two papers used quantitative methods (Table 1.2), and four papers used mixed methods (Table 1.3).

### **Overview of Papers**

The final papers included in the current review were grouped according to the theoretical model used to inform the team formulation meeting(s), and summarised below. All 11 studies report outcomes associated with psychologist-led team formulations that took place in the United Kingdom. For clarity, findings are synthesised in a subsequent section of this review thus omitted from this overview.

### ***Cognitive-Behavioural Framework***

The papers in this category (Berry, Barrowclough & Wearden, 2009; Berry et al., 2015; Craven-Staines, Dexter-Smith & Li, 2010; Murphy, Osborne & Smith, 2013; Wainwright & Bergin, 2010) all report having used a cognitive-behavioural framework during the team formulation, which typically conformed to Beck's (1976) longitudinal model. That is to say the team formulations were structured around: exploring what is known about significant events in the service user's past; the impact of these on beliefs about themselves, others and life; and the interaction between their behaviour, emotional state, and physiological responses in terms of maintaining the presenting difficulties. However, two studies also report having utilised complimentary ideas from interpersonal approaches such as attachment theory (Berry et al., 2009; Murphy et al., 2013).

Four of the papers in this category report having developed the team formulation to the point at which this informed care, with the exception of Murphy et al. (2013) who do not comment on this. Team formulations were either linked with support plans (Berry et al., 2009; Berry et al., 2015; Wainwright & Bergin, 2010), or summarised in diagrammatic form (Craven-Staines et al., 2010).



Berry et al. (2009) investigated the effects of the team formulation process on staff appraisals of service users' mental health problems and attitudes towards their clinical work. Thirty registered mental health nurses (RMHNS) and support workers working with male service users with a diagnosis of schizophrenia in a psychiatric rehabilitation setting completed questionnaires pre- and post-team formulation. These were then analysed using repeated measures *t*-tests.

Berry et al. (2015) used a single-blind randomised design to ascertain the effects of multiple team formulation meetings relative to treatment as usual (TAU) across several inpatient wards. The sample comprised 51 service users with complex mental health needs, and 85 staff members including RMHNS, support workers, occupational therapists (OTs), and ward managers. Participants completed a range of standardised measures of staff-service user relationships, staff wellbeing, and service user functioning at assessment and after six months; case notes were also reviewed with regards to any changes in the level of care provided including service users' freedom on the ward, prescribed medication and length of inpatient stay. Analysis was undertaken on an intention-to-treat (ITT) basis using regression and *t*-tests to control for clustering effects, differences in baseline scores, and the loss of participants in each condition at follow up.

Craven-Staines et al. (2010) evaluated a team formulation model being used across several community and inpatient mental health services for older adults. Twenty qualified and assistant staff (including nurses, OTs, social workers, and health care assistants) were interviewed concerning their views on team formulation meetings in terms of their purpose, theoretical model, benefits and barriers of the process, and desired changes to their format. Transcripts were read individually by the three authors and then discussed until a consensus regarding the key super- and sub-ordinate themes was reached.

Murphy et al. (2013) interviewed 10 qualified/assistant nurses and OT assistants working in older adult inpatient units, regarding their perceptions of the formulation-led team consultations they had attended. Thematic analysis (Braun & Clarke, 2006) was used to explore participants' views on the ways in which team

formulation impacted on their daily practice, and the mechanisms of change involved.

Wainwright and Bergin (2010) sought to capture the views of five staff (two RMHNS, a healthcare support worker, an OT, and a medical doctor) concerning the use of a team formulation pilot in an acute ward for older women with functional mental health problems. Semi-structured interviews were undertaken prior to and following the pilot project and subjected to thematic analysis. A content analysis was also performed to compare the number of psychological inferences participants made when describing a service user's problems pre- and post-team formulation.

### ***'Five Ps' Approach***

Papers in this category identify having utilised a pantheoretical '5Ps' approach when formulating with teams (cf. Dudley & Kuyken, 2006; Ingham, Clarke & James, 2008). Use of this framework seeks to help the team understand an individual's psychosocial difficulties in terms of the relationship between their current problems (presenting issues) and factors which: contributed to the problems starting (predisposing), maintain the problems (perpetuating), trigger the problems (precipitating), and prevent the problems from escalating (protective).

Ingham (2011) evaluated the impact of formulation workshops with a residential care staff team supporting an individual with an intellectual disability (ID) experiencing complex psychosocial difficulties. In addition to daily interval recordings of challenging behaviours displayed by the service user, seven direct care staff members completed questionnaires regarding their perceptions of the presenting problems and satisfaction with the team formulation process before, during and after the intervention. No formal analytic method seems to have been applied but descriptive data is presented.

Ingham, Selman and Clarke (2011) evaluated formulation workshops in an inpatient setting for people with ID. Forty eight multidisciplinary staff completed a survey featuring Likert scales and an open-ended question regarding the

perceived effectiveness and satisfaction with team formulation. Ratings were collated and described, supported by a thematic analysis.

### ***Cognitive Analytic Consultancy***

Kellett, Wilbram, Davis and Hardy (2014) used a mixed-methods randomised control design to evaluate the impact of formulation-based consultancy intervention (cf. Carradice, 2013) in an Assertive Outreach team on service user and team functioning, compared with TAU. Following training on cognitive analytic therapy (CAT) concepts such as sequential diagrammatic reformulations (Ryle, 2004), key staff members were supported to identify the dysfunctional roles and procedures adopted by both the service user(s) and team. These formulations were then shared in whole-team supervision meetings, and used to develop new ways of working with the service user. Participants were required to complete standardised measures at different time points, and comprised 20 service users with severe and enduring mental health problems, and multidisciplinary team members with care coordination responsibilities. Eight staff also agreed to be interviewed. Application of Friedman's Test assessed whether quantitative change had occurred within the different conditions, whilst an inductive content analysis (Elo & Kyngas, 2008) was used to identify key categories from interview transcripts post-team formulation.

### ***Systemic Concepts***

Wilcox (2013) used a survey evaluation of staff views concerning the impact of multidisciplinary reflective practice meetings on clinicians' practice and/or understanding of clients within a community ID team. Meetings led to a shared formulation and action plan agreed by the team, and were based on an adaptation of Lake's (2008) team consultation framework. Less emphasis was placed on speculating about the service users' beliefs during the team formulation, instead focusing on exploring the multiple dominant and alternative narratives held by the team about their clinical work and the service user (cf. Freedman & Combs, 1996). Between three and ten questionnaires were received after each meeting, though these were not administered routinely. Due to having only sought anonymous responses it is unclear whether the same participants contributed views at multiple

time points. In the absence of a formal analytic method, participants' mean ratings and narrative responses were summarised.

### ***Indeterminate Formulation Models***

The remaining papers provide limited information regarding the specific approach or theoretical model used during the team formulation session(s), concentrating instead on a qualitative exploration of their findings.

Collins (2011) reported on the impact of developing “integrative psychological formulations” (p. 50) within reflective practice meetings for inpatient mental health staff teams. Interviews with nine participants comprising RMHNs, healthcare assistants and an OT were analysed using grounded theory (Charmaz, 2006), to investigate how staff experienced, processed and applied psychological knowledge in their clinical practice. A theoretical model is proposed, supported by exemplar quotes.

Finally, Herhaus (2014) interviewed five clinical psychologists, four non-psychologist staff members, and six service users to ascertain multiple perspectives on team formulation meetings in an early intervention first episode psychosis service. Grounded theory was applied until a model emerged.

Table 1.1

*Characteristics of included qualitative studies.*

Reference	Purpose/Aims	Methodology & Participants	Team Formulation	Findings
(1) Collins (2011)	To understand how reflective practice groups using formulations impacted on staff's psychological understanding & clinical practice	Grounded Theory Multidisciplinary ward staff (N=9)	Reflective practice groups structured using integrative formulations	Groups increased understanding through guided reflection, developing theory-practice links and validation. This enhanced capacity for mentalisation leading to a more compassionate and empathic stance.
(2) Craven-Staines, Dexter-Smith & Li (2010)	To explore staff perceptions of team formulation meetings	(Unclear analysis) Multidisciplinary CMHT and ward staff (N=20)	Structured using CBT formulations Some participants had undertaken prior training in formulation	'Clinical Implications' – improved understanding, insight, care planning, & dissemination of information; 'Impact upon the Service' – improved MDT working & clarified roles, but required time investment. Aforementioned aspects enhanced by training and routine practice of team formulation.

(3) Herhaus (2014)	To explore the experience of team formulation meetings from multiple perspectives	Grounded Theory  Multidisciplinary staff ( $n=9$ ) & service users ( $n=6$ ) from an early intervention service	Meetings used indeterminate formulation framework	Sessions lead to a shared understanding which helped the team to support service users; achieved by broadening perspectives, promoting consistency and empathy, managing uncertainty, opening-up alternatives for responding, developing working relationships & promoting engagement.
(4) Murphy, Osborne & Smith (2013)	To explore how formulation-led team consultations impacted on daily practice & the mechanisms of change involved	Thematic Analysis  Multidisciplinary ward staff ( $N=10$ )	Mainly structured using CBT formulations preceded by training on clinical skills & formulation	Themes included: 'It makes you understand the reasons why people are like they are'; 'It depends on the patient'; 'The importance of visibility & accessibility'; 'Impact on team efficiency'; and 'Impact on feelings invoked by the workplace'.
(5) Wainwright & Bergin (2010)	To capture staff's views of team formulation	Content & Thematic Analysis  Multidisciplinary ward staff ( $N=5$ )	Using CBT framework	Formulation meetings led to: Better understanding of service users, more consistent approach, greater empathy & tolerance, inclusion of psychological factors in care plans, and making more causal inferences when explaining a service user's problems

Table 1.2

*Characteristics of included quantitative studies.*

Reference	Purpose/Aims	Methodology & Participants	Team Formulation Intervention	Findings (Outcome measures used)
(6) Berry, Barrowclough & Wearden (2009)	To explore the effects of team formulation on staff appraisals of service users	Quasi-experimental pre-/post-test without comparison group  RMHNs & support workers (N=30)	Based on CBT & interpersonal frameworks	Significant changes in staff perceptions of service users' problems on all dimensions (IPQ; IPQ-S). Service users perceived as putting more effort into recovery & less responsible for causing their problems. Increased ratings of: treatment efficacy, understanding of issues, confidence in work, staff and service users' control of their problems. Less negative feelings towards service users.
(7) Berry, Haddock, Kellett, Roberts, Drake & Barrowclough (2015)	To evaluate the feasibility and efficacy of a team formulation intervention on staff-service user relationships & clinical outcomes	Single-Blind Cluster RCT  Multidisciplinary ward staff (n=85) & inpatients (n=51)	Based on cognitive model	Staff did not perceive any changes in working alliances (WAI; WAS). Service users felt significantly less criticised by staff and that the ward atmosphere had improved (PCS; WAS). No significant change in staff wellbeing (GHQ-28; MBI-EE/-PA) but depersonalisation significantly lower (MBI-DP). No significant change in clinical outcomes for service users (PANSS; GAF; SBS; relapse rates, medication reductions, or freedom/length of stay on the ward).

Table 1.3

*Characteristics of included mixed method studies.*

<b>Reference</b>	<b>Purpose/Aims</b>	<b>Methodology &amp; Participants</b>	<b>Team Formulation Intervention</b>	<b>Findings (Outcome measures used)</b>
<b>(8)</b> Ingham (2011)	To evaluate the impact of a team formulation workshop on incidence and severity of a service user's psychosocial difficulties	Case Study using Pre-/Post- Design  Residential care staff (N=7)	5Ps framework	Subsequent reduction in behaviours that challenge & less perceived impact on other residents; formulation linked with developing staff's skills & understanding.
<b>(9)</b> Ingham, Selman & Clarke (2011)	To evaluate the perceived effectiveness & satisfaction with formulation-based working	Descriptive & Thematic Analysis  Multidisciplinary ward staff (N=48)	5Ps framework  Predated by training in biopsychosocial formulation	Likert-scale responses indicated staff benefitted from team formulation; Themes included: 'Sharing information', 'Developing a new, shared understanding', & 'Facilitating MDT working'.



(10)	Kellett, Wilbram, Davis & Hardy (2014)	To explore the impact of formulation-led team consultancy on service user outcomes, team climate, and team practices	RCT including Qualitative Content Analysis Multidisciplinary staff ( $n=8$ ) & service users ( $n=20$ ) from an assertive outreach service	Team consultations using CAT formulations, followed by team supervision  Preceded by training on CAT	No significant changes in service users' distress (CORE-OM), functioning (WSAS), or engagement with the team (SES). Case consultation led to significant improvement in team climate (TCI) in terms of participative safety ( $d=1.72$ ), support for innovation ( $d=2.42$ ), & task orientation ( $d=.30$ ).  Qualitative themes included: 'Increased awareness', 'Changes made to the clinical approach', and 'Enhanced teamwork' associated with use of the CAT model.
(11)	Wilcox (2013)	To summarise, evaluate & reflect upon case formulation meetings	Case study  CMHT professionals ( $N=unclear$ )	Meetings used systemic formulations	Helped staff to: understand the client's/family's reactions. Perceived positive impact on relationship & confidence working with service users, and management of risk.

*Note.*

**Outcome measures:** CORE-OM=Clinical Outcomes in Routine Evaluation Outcome Measure, GAF= Global Assessment of Functioning Scale, GHQ-28=General Health Questionnaire, IPQ=Brief Illness Perception Scale, IPQ-S= Brief Illness Perception Scale for Schizophrenia, MBI=Maslach Burnout Inventory (-EE=Emotional Exhaustion, -PA=Personal Accomplishment, -DP=Depersonalisation), PANSS=Positive & Negative Syndrome Scale, PCS=Perceived Criticism Scales, SBS=Severe Behaviour Schedule, SES=Service Engagement Scale, TCI=Team Climate Inventory, WAI=Working Alliance Inventory, WAS=Ward Atmosphere Scales, WSAS=Work & Social Adjustment Scale.

**Other abbreviations:** CAT=Cognitive Analytic Therapy, CBT=Cognitive Behaviour Therapy, CMHT=Community Mental Health Team,  $d$ =Cohen's  $d$  (effect size), MDT=Multidisciplinary Team, RMHN=Registered Mental Health Nurse.

Table 1.4

*Quality appraisal criteria met by each study, strengths and limitations.*

Reference	Criteria met by critical appraisal tool	Strengths	Limitations
(1)	97%	Clear analytic process; Presents theoretical model grounded in data	Low generalisability, as small <i>N</i> & not representative of wider team
(3)	94%	Method clear & replicable; Good reflexivity	SUs interviewed, but they hadn't attended the team formulation session
(6)	87%	Replicable procedure; OMs with good psychometric properties used	Risk of type I error as multiple t-tests used
(7)	83%	Randomised design; ITT undertaken to reduce selection bias	Small <i>N</i> therefore limited power; Unclear whether groups equal at baseline
(4)	83%	Minimised researcher bias; Good description of participants' context	No examples of analysis; Clinical implications unclear
(10)	83%	Use of mixed methods within randomised design; Replicable	Small <i>N</i> ; Some staff in both experimental conditions - risk of contaminated results
(9)	65%	Mixed methods results consistent within study; Examples cited to support themes	Survey responses positively biased; Long FU interval may limit staff recall
(2)	58%	Inter-coder reliability for themes; Data collection process clear	Opportunity sample increases risk of bias; Method of analysis unclear
(8)	52%	Range of outcomes considered; Example team formulation provided	Case study limits generalisability; Risk of confounding variables due to FU period
(5)	47%	Efforts to reduce social desirability bias; Replicable data analysis procedure	No credibility checks; Analytic process unclear
(11)	44%	Example narrative response provided; Considered ethical issues	Risk of selection bias as inconsistent evaluation; High rate of attrition

*Note.* *N*=sample size, ITT=intention to treat analysis, OMs=outcome measures, FU=follow up.

## **Quality Assessment**

In addition to scoring the relevant critical appraisal tool, the key strengths and weaknesses of the included papers are summarised below (see also Table 1.4).

### ***Design***

Several studies sought to evaluate the effectiveness of team formulation using either quasi-/experimental designs (Berry et al., 2009; Berry et al., 2015) or quantitative analysis within a mixed methods design (Ingham, 2011; Ingham et al., 2011; Kellett et al., 2014; Wilcox, 2013).

Of these, two were high quality randomised control studies: Berry et al. (2015) randomly assigned whole ward teams to either receive a team formulation intervention or not, controlling for clustering effects and loss of participants to drop out through their analysis; Kellett et al. (2014) randomly allocated service users into either the experimental condition or TAU, though several staff participants worked with service users in both conditions. Staff may have applied ideas from the team formulation intervention in their work with service users in the TAU condition, thus contaminating their results. Replication of Kellett et al.'s (2014) study using a randomised cluster design may overcome this limitation. The absence of a control group in the other studies fails to exclude the potential influence of other factors, such as concurrent interventions and/or changes within the team (cf. Ho, Peterson & Masoudi, 2008).

Six qualitative papers (Collins, 2011; Craven-Staines et al., 2010; Herhaus, 2014; Ingham et al., 2011; Murphy et al., 2013; Wainwright & Bergin, 2010) and two of the mixed methods studies (Kellett et al., 2014; Wilcox, 2013) sought to explore participants' subjective experiences and views on team formulations.

### ***Sampling and Participants***

The majority of quantitative and mixed-method papers provided a good overview of pertinent participant demographics, minimising selection bias by inviting all eligible staff who had participated in a team formulation to take part in the study and achieving a minimum response rate of 52% (Berry et al., 2009; Berry et al., 2015; Ingham, 2011; Ingham et al., 2011; Kellett et al., 2014). The varied

administration of evaluation measures in Wilcox's (2013) evaluation may have biased results by not consistently capturing the views of those who had been involved in the formulation process. The sample of staff was representative of the wider team in only three studies (Berry et al., 2009; Berry et al., 2015; Kellett et al., 2014); the remaining mixed-method papers gave insufficient information to ascertain this, and in doing so limited the generalisability of their findings.

Recruitment strategies were generally appropriate across qualitative studies. For example, Collins (2011) and Herhaus (2014) used purposive sampling to recruit participants likely to provide information and insight concerning the impact of sessions using team formulation, and the processes involved. This enhanced the studies' validity (Strauss & Corbin, 2008), although the use of opportunity sampling in others makes it difficult to determine the integrity of the evidence given difficulties replicating recruitment (Craven-Staines et al., 2010; Wainwright & Bergin, 2010). Participants across all qualitative and mixed methods studies comprised multidisciplinary staff (e.g. RMHNS, healthcare support staff, social workers); only one study interviewed service users regarding their views, although as participants had not attended meeting(s) the rationale for including service users was unclear (Herhaus, 2014).

### ***Data Collection***

Three studies employed reliable and validated measures, increasing confidence in their observed effects (Berry et al., 2009; Berry et al., 2015; Kellett et al., 2014). Others used bespoke evaluation measures and surveys with unknown psychometric properties (Ingham, 2011; Ingham et al., 2011; Wilcox, 2013). Unvalidated measures tend to yield descriptive data, and in the current instance were insufficient to rigorously demonstrate causal relationships between team formulation and subsequent outcomes (Walford, Tucker & Viswanathan, 2010).

Berry et al. (2015) was the only study to have used assessors who were naïve to participants' experimental group membership. Blinding assessors and investigators within research designs comparing two interventions, in this case team formulation versus TAU, is an effective method of increasing findings' validity

as it reduces opportunity for bias to lead to the differential assessment and evaluation of outcomes (Schulz & Grimes, 2002).

Qualitative methodology was appropriate in all cases, and is typically associated with eliciting participants' subjective perspectives through semi-structured interviews (Willig, 2013), although the researcher's presence can limit the expression of socially undesirable views (Tourangeau & Yan, 2007). This might have resulted in positive views of team formulation being overrepresented. Designs attempted to minimise this bias through using anonymous surveys (Ingham, 2013; Ingham et al., 2011; Wilcox, 2013), and minimizing the involvement of clinicians who were associated with the delivery of the team formulation intervention with participants (Craven-Staines et al., 2010; Murphy et al., 2013; Wainwright & Bergin, 2010) to facilitate participants' candid responses. Reflexivity regarding the researcher's personal and epistemological impact on the research process is also an important means of increasing findings' validity (Willig, 2013). Three studies (Collins, 2013; Herhaus, 2014; Murphy et al., 2013) acknowledged the possibility of researcher bias on the interpretation of findings and made efforts to reduce this through reflective supervision and/or journal-keeping.

### ***Level of Analytical Rigour***

Whilst several studies reported statistically significant change post-team formulation (Berry et al., 2009; Berry et al., 2015) and large effect sizes (Kellett et al., 2014), their power to detect further effects was limited by small sample sizes and the loss of participants at follow up.

The methodological quality of service evaluations (Ingham, 2011; Ingham et al., 2011; Wilcox, 2013) and one empirical paper (Berry et al., 2009) would have been enhanced through the use of appropriate inferential statistics to minimise the risk of false positive findings (Type I errors). For example, Ingham (2011) presented data visually to support his hypothesis, but did not ascertain the likelihood that such extreme changes might be due to factors other than the team formulation intervention thus limiting the impact of his results within the literature.

Four of the qualitative papers used recognised analytic methods (e.g. grounded theory, thematic analysis), grounding their interpretations in the data and supporting themes with multiple exemplars to increase the reliability of findings (Collins, 2011; Herhaus, 2014; Kellet et al., 2014; Murphy et al., 2013). However, perhaps given the brevity of practice-based evidence reports, others' methods of qualitative analysis were often unclear and findings lacked depth (Craven-Staines et al., 2010; Ingham, 2011; Ingham et al., 2011; Wainwright & Bergin, 2010; Wilcox, 2013). For example, Ingham (2011) and Wilcox (2013) both present a descriptive rather than exploratory summary of participants' views.

Models of the processes involved in the impact of team formulation were proposed by two good quality studies (Collins, 2011; Herhaus, 2014); these could be investigated further in future research, such as using path analysis to ascertain the magnitude and significance of the theorised component variables (cf. Garson, 2014).

Credibility of qualitative findings was checked in a variety of ways: cross-checking analysis (Herhaus, 2014; Murphy et al., 2013) and/or using multiple coders to verify themes (Collins, 2011; Craven-Staines et al., 2010); triangulating results between different groups of participants (Herhaus, 2014); and checking findings with respondents (Collins, 2014). Three studies neglected to report similar steps thus the validity of findings is questionable (Ingham, 2011; Wainwright & Bergin, 2010; Wilcox, 2013).

## **Synthesis of Findings**

The findings from the 11 reviewed studies are synthesised below. As the included studies reported findings from multiple methodological perspectives, a thematic analysis based on guidance by Braun and Clarke (2006) was undertaken to identify pertinent themes across quantitative and qualitative results. The two randomised trials included in this review (Berry et al., 2015; Kellett et al., 2014) used different outcome measures, thus a meta-analysis was not feasible. Studies were read thoroughly, and any findings relating to the current review question were noted as bullet points and subsequently coded. Reported findings that did not address the review question were not included in the current synthesis (e.g. results relating to other aspects of services beyond team formulation). The coded findings were then grouped into themes by clustering similar findings together. Themes were subsequently reviewed and refined, and named to reflect the nature of outcomes yielded by team-based formulation sessions.

Four themes were developed to synthesise the findings identified in the current review (Table 1.5). Qualitative and quantitative results are discussed as they relate to each theme.

Table 1.5

*Overview of themes summarizing included studies' findings.*

<b>Main theme:</b>	<b>Subthemes:</b>	<b>Codes:</b>	<b>References:</b>
1. Relating Better to Service Users	Understanding service users	Psychosocial factors; Historical perspectives; Wider systems; Reframing behaviour; Theory-practice links	(1, 2, 3, 4, 5, 6, 7, 8, 9, 10)
	Developing new insights	Reflective practice; Increasing empathy; Avoiding problems	
2. Lack of Direct Benefit to Service Users		Lack of effect; Reduction in behaviour; Ongoing distress	(7, 8, 10, 11)
3. Benefitting Staff?	Supporting workers	Reducing frustration; Tolerating emotions; Containing; Validation; Feeling vulnerable; Confidence; Optimism; Continued burnout	(1, 3, 4, 5, 6, 7, 8, 10, 11)
	Changes to clinical practice	New responses; Less stuck; Refreshing; Not directive	
4. Effects on the Organisation	Team climate	MDT working; Innovation; Care of colleagues; Caseload management; Better organised	(1, 2, 3, 4, 7, 9, 10)
	Consistent approaches	Coming together; Managing complexity; Whole-team approach	
	Sharing information, skills and responsibility	Disseminating information; Sharing information; Negotiating roles; Delegating responsibilities; Sharing experiences; Overlooking details	



### ***Theme 1: Relating Better to Service Users***

This major theme was shared across all papers in the review. The impact of team formulations in terms of relating differently to service users comprised two connected subthemes:

#### ***Understanding service users***

Team formulation sessions enabled clinical staff to achieve a deeper understanding of service users through constructing a coherent narrative(s) about the development and maintenance of their mental health issues and interpersonal difficulties (Berry et al., 2009; Collins, 2011; Herhaus, 2014; Ingham, 2011; Ingham et al., 2011; Kellett et al., 2014; Murphy et al., 2013; Wainwright & Bergin, 2010). Exploring the relationship between pertinent psychosocial factors and service users' problems as a team, helped staff to understand clients' behaviour in the context of their historical experiences (Collins, 2011; Herhaus, 2014; Murphy et al., 2013) and wider systems (e.g. family/social environment; Herhaus, 2014). To this extent team formulations were speculated to have the potential to shift service culture away from a purely medical view of emotional distress (Berry et al., 2015; Collins, 2011; Herhaus, 2014; see also Theme 4).

Service users described that greater consistency in staff responses post-team formulation left them 'feeling known' as individuals (Herhaus, 2014). Formulating in teams seems to have increased the use of psychological inferences when describing service users, such as self-harm being perceived as help-seeking behaviour (Craven-Staines et al., 2010; Wainwright & Bergin, 2010). Significant shifts in the way staff thought about service users was also demonstrated by Berry et al., (2009); post-team formulation, staff increasingly attributed causes for service users' difficulties to contextual factors and rated service users as being more active and capable in their recovery, and had a renewed appreciation for service users' lived experiences. Furthermore, regular involvement in formulation sessions significantly reduced staff's self-reported unfeeling and impersonal responses towards service users (i.e. levels of depersonalisation on the Maslach Burnout Inventory (MBI - Maslach & Jackson, 1981; Berry et al., 2015).

For staff participants, there was some evidence to suggest that the transition to more contextualised understandings of service users was underpinned by several processes. The facilitatory group context was theorised to first provide emotional containment for staff, from which participants could explore psychological understandings of service users through a process of guided reflection and developing theory-practice links. This was reinforced through receiving validating feedback from the facilitator (Collins, 2011).

### *Developing new insights*

Team formulations enabled some staff to recognise dynamic factors between the team and service user through increasing reflective practice and psychological frameworks (Collins, 2011; Herhaus, 2014). Formulation sessions appear to have impacted on staff's self-awareness regarding their own emotional responses to service users, conceptualised in terms of unconscious psychological processes (transference and counter transference reactions) that occur between staff and service users. This new insight into service users' subjective experiences (i.e. mentalisation) enabled some staff to relate more empathically (Collins, 2011; Herhaus, 2014) and avoid unhelpful interactions; for example, by planning endings carefully with service users with a history of abandonment and rejection (Kellett et al., 2014; Murphy et al., 2013). Sessions also seemed to have generated some interest in psychotherapeutic approaches (Collins, 2011).

### ***Theme 2: Lack of Direct Benefit to Service Users***

There was no significant support for team formulation directly yielding positive clinical outcomes for service users in terms of subjective wellbeing, emotional distress or global functioning.

Practice-based evidence suggested that team formulations were associated with a reduction in the incidence and perceived severity of challenging behaviours of a resident with ID (Ingham, 2011), and having a positive impact on the subjective confidence of a small number of staff when managing service users' level of risk (Wilcox, 2013). However, more methodologically rigorous studies failed to detect an effect on service user's self-reported emotional or behavioural problems. Compared to TAU, Berry et al. (2015) noted that regular formulation meetings with

ward staff yielded no significant difference in: the severity, intensity or frequency of symptoms or behaviours that challenge; nor change in medication reduction, personal freedoms or length of stay on the ward for inpatients with psychosis. However, service users experienced the team as more supportive and involved, despite staff who regularly participated in team formulations perceiving themselves as more critical of service users. Similarly, Kellett et al. (2014) found that a formulation consultancy model yielded no significant reductions in service users' psychological distress, level of disability, or engagement with the assertive outreach team. This later finding was somewhat surprising given the emphasis on conceptualising and proactively managing unhelpful staff-service user interactions.

### ***Theme 3: Benefitting Staff?***

Formulation sessions appear to have some benefits for multidisciplinary staff members and their clinical work, considered through the subsequent subthemes:

#### ***Supporting workers***

This subtheme attracted mixed results from included studies, with methodologically rigorous investigations both confirming and denying a notable benefit of team formulation in terms of supporting workers.

Several studies identified supportive aspects to team formulations. In particular, discussing the relational aspects of working with clients with complex mental health needs in team formulation sessions was deemed helpful by staff; it reduced feelings of frustration, helped manage work-related stress and tolerate difficult feelings (Collins, 2011; Murphy et al., 2013). Many staff found it containing to have a discrete forum in which to develop knowledge and skills (Ingham, 2011), explore concerns, process clinical issues, and reflect on practice without fear of judgement or sanction (Collins, 2011; Herhaus, 2014). Non-qualified staff members felt valued and empowered through participating in formulation sessions and reported increased job satisfaction (Murphy et al., 2013). Although team formulation sessions were an important source of validation and recognition for some staff (Collins, 2011) for others participation led to feeling vulnerable, due to exposing their professional competency and exploring their reactions to clients (Herhaus, 2014).

Multiple papers reported that team formulation meetings inspired staff confidence and self-efficacy in addressing service users' problems, potentially arising through the formulation having enhanced the team's understanding of service users' needs and problems, precipitating ideas for intervention and greater optimism for change (Berry et al., 2009; Collins, 2011; Ingham, 2011; Wilcox, 2013). Given the high stress circumstances in which they work, it is unsurprising that staff experience high degree of burnout, which the aforementioned results suggest may be alleviated through team formulation. However, when comparing well-validated measures of staff wellbeing (General Health Questionnaire-28; Goldberg & Hillier, 1979) and burnout (MBI) post-team formulation, there was no significant difference in participants' self-reported psychological distress, feelings of emotional exhaustion, or professionals' sense of personal accomplishment in their work (Berry et al., 2015).

#### *Changes to clinical practice*

This subtheme includes the finding that team formulations precipitated new ways of responding to service users' underlying needs as identified through the formulation, although the supporting papers provide limited examples of how exactly this translated into practice (Collins, 2011; Herhaus, 2014; Ingham, 2011; Wilcox, 2013). Collins' (2011) model of the processes involved in developing psychological understanding in teams suggests that by extending their reflective practice skills, staff participants reached a more compassionate and empathic position in their relationships with service users enabling them to translate the formulation information into psychologically informed clinical practice. In some cases staff identified beginning to feel 'less stuck' when working with hard to engage service users post-team formulation, due to recognising and steering clear of unhelpful patterns identified through the formulation process as maintaining the service users' problems (Kellett et al., 2014; Murphy et al., 2013). For several staff the meetings gave impetus and refreshed purpose to clinical work through making sense of service users' presentations and giving advice (Herhaus, 2014; Kellett et al., 2014), although some participants felt that formulation sessions were not directive enough to alter practice (Wainwright & Bergin, 2010).

#### ***Theme 4: Effects on the Organisation***

Adopting a team formulation approach appeared to yield a number of organisational benefits within the service with minor drawbacks, summarised in the following subthemes:

##### ***Team climate***

Staff across a range of settings reported that team formulation facilitated multidisciplinary working (Craven-Staines et al., 2010; Ingham et al., 2011), enhanced teamwork and had a significantly positive effect on the team climate (Kellett et al., 2014). For example, formulation sessions were linked with significantly more support for innovation within the team (Kellett et al., 2014), potentially facilitated by the team meeting together to share their clinical experience and identify solutions to problematic interactions with service users. Staff also identified taking better care of colleagues given improved communication and a more comprehensive understanding of the team's caseload acquired through the formulation process. Wards that routinely engaged in a team formulation process were perceived by service users as being more organised relative to others without this provision (Berry et al., 2015). Staff participants in Collins's (2011) study reported that sessions restored belief in the team's capacity to help service users by sharing feelings of hopelessness and incompetence in the group and identifying new ways of responding. This is potentially significant given the importance of a secure base, hopeful outlook and emotionally containing environment to recovery in mental health (Gumley & Park, 2010).

##### ***Consistent approaches***

Coming together to integrate different perspectives into a consistent whole-team approach was linked with staff feeling more able to manage complex presenting situations (Collins, 2011; Craven-Staines et al., 2010; Herhaus, 2014; Kellett et al., 2014; Murphy et al., 2013). This was perceived as especially important for service users whose developmental histories have lacked reliable attachments with attuned caregivers (Herhaus, 2014), and those for whom the team can become 'split' as a means of defending against overwhelming feelings of anxiety (Collins, 2011).

### *Sharing information, skills and responsibility*

Team formulation sessions reportedly facilitated inter-professional communication (Kellett et al., 2014) and were helpful in drawing together and disseminating significant amounts of client-related information (Craven-Staines et al., 2010; Herhaus, 2014; Ingham et al., 2011; Kellett et al., 2014). Sessions were a setting for negotiating and delegating clinical responsibilities relating to service users' care (Herhaus, 2014). Meetings also provided an opportunity to recognise and share knowledge and skills across disciplines and levels of experience (Collins, 2011; Craven-Staines et al., 2010), although staff working on a ward for older adults with dementia felt their contributions to the team formulation process were less valued because the framework used minimised organic factors (Murphy et al., 2013).

## DISCUSSION

This review aimed to provide a synthesis and critique of the current evidence pertaining to the use of team formulation sessions and their impact in secondary mental health settings. A systematic search of the literature identified 11 suitable papers that used a variety of quantitative and qualitative methodological approaches. Team formulations were psychologist-led sessions involving a range of qualified and non-qualified multidisciplinary staff. Most studies employed a cognitive-behavioural framework to structure the session (Berry et al., 2009; Berry et al., 2015; Craven-Staines et al., 2010; Murphy et al., 2013; Wainwright & Bergin, 2010), although other biopsychosocial, interpersonal, dynamic and systemic concepts were also utilised to co-construct an understanding of service users' difficulties and inform potential ways of responding (Collins, 2011; Herhaus, 2014; Ingham, 2011; Ingham et al., 2011; Kellett et al., 2014; Wilcox, 2013).

A critical appraisal of the studies identified variance in the level of methodological quality, with service evaluations struggling to demonstrate a high degree of rigour though lack of analytic transparency, credibility checks, and small sample sizes. Several high quality studies were reported, including two utilising randomised experimental designs (Berry et al., 2009; Kellett et al., 2014) and rigorous qualitative methodology (Collins, 2011; Herhaus, 2014; Murphy et al., 2013). Confidence in results was inspired through the use of control groups and advanced statistical analysis in quantitative designs, and reflexivity in some qualitative designs; together these aspects minimised the risk of drawing false conclusions in empirical studies. Whilst this went some way to control for eliciting socially desirable responses from participants, the dominance of interview designs increases the likelihood that participants may have been loathed to express critical perspectives on team formulations, which were relatively absent in findings.

Using a thematic analysis, relevant findings were synthesised and four major themes emerged: (1) 'Relating better to service users', (2) 'Lack of direct benefit to service users', (3) 'Benefitting staff?', and (4) 'Effects on the organisation'. Whilst limited in quality, practice-based evidence was useful in evaluating and supplementing the findings from empirical research. Team formulation was

associated with reports of improved relationships between staff and service users across all papers; teams reported having developed a deeper empathic understanding of service users clients in terms of the development and maintenance of their difficulties, which supported better relationships between staff and service users (Berry et al., 2009; Herhaus, 2014). These findings are consistent with previous literature; for example, the strengthening of the working alliance between therapist and service users through formulating in psychotherapy (Aston, 2009; Redhead et al., 2015), and increasing multidisciplinary staff team's psychological thinking (Dexter-Smith, 2007, 2010; Hood et al., 2013).

The review shows that team formulation sessions had a minimal impact on service users' clinical outcomes (Berry et al., 2015; Kellett et al., 2014s), but were regarded as a useful forum to evaluate and plan individualised care (Craven-Staines et al., 2013; Murphy et al., 2013). Similarly, past investigations have found little added benefit to client's immediate emotional wellbeing from individualised approaches versus standardised interventions (Emmelkamp et al., 1994; Schulte et al., 1992).

However, within a team formulation, one might also regard the staff group as service users of a psychological resource. Staff reported feeling supported and encouraged in their work with complex difficulties post-formulation (Collins, 2011; Ingham, 2011; Murphy et al., 2013) which parallel's Redhead et al.'s (2015) finding that psychotherapy formulations support service users' self-efficacy. However, this review found little evidence that team formulation improved staff members' wellbeing or work-related stress, with the exception of reducing depersonalisation (Berry et al., 2015).

Finally, several studies in the current review linked team formulation with a number of organisational changes in terms of teams feeling more cohesive, better interdisciplinary communication, and increasing consistency/continuity of care for service users (Berry et al., 2015; Ingham et al., 2011; Kellett et al., 2014; Herhaus, 2014). Similar outcomes from less formal methods of 'chipping in' formulation ideas in team have also been identified elsewhere (Christofides et al., 2012; Hood et al., 2013). Together this evidence suggests that the content as well as process



of psychological formulation is valued by mental health teams. Literature from organisational psychology stresses that for teams to work most effectively (i.e. focusing on achieving collective goals and preventing problems from emerging), a climate of 'psychological safety' is required in which individuals are able to contribute ideas, admit ignorance, acknowledge uncertainty, and voice concerns (Dollard & Bakker, 2010; Edmondson & Lei, 2014). To do so requires the organisation to manage the interpersonal threat arising from this, such as by recognising the interdependence of the team in pursuit of a shared enterprise and senior figures modelling curiosity (Edmondson & Lei, 2014), and developing closer working relationships (Carmeli, Brueller & Dutton, 2009). Team formulation sessions have the potential to provide such an opportunity, as identified through the themes of the current review,

### **Clinical Implications and Recommendations**

Team formulation sessions represent a relatively low intensity organisational intervention, with the potential to improve service user and clinical staffs' experiences of working together through developing shared understanding and new ways of relating in the context of mental health services (Berry et al., 2015; Herhaus, 2014). This may be particularly relevant for supporting teams to establish and develop positive working relationships with difficult to engage clients and those who challenge services, for whom individual psychological approaches (i.e. psychotherapy) may not be appropriate (Ingham et al., 2011; Kellett et al., 2014). Underpowered studies are unlikely to detect an effect, thus future research using larger sample sizes would be prudent particularly with regards to the effect of team formulation approaches on staff and service user outcomes in the long term.

Psychological formulation is unstandardised in nature, and thus comparing the findings of studies employing different frameworks with unique teams and service users will always be challenging. Future quantitative research could employ cluster randomised designs using a standardised battery of outcome measures to ascertain the significance and magnitude of the effects of team formulation, with respect to the pertinent areas identified in this review (e.g. team climate, quality of alliances with service users).

### **Strengths and Limitations of the Review**

This is the first review to utilise a systematic approach to identifying and critically appraising the literature on team formulations since the publication of *New Ways of Working* (DoH, 2007; Onyett, 2007). The inclusion of grey literature and hand searching techniques yielded further papers that would have been overlooked by focusing purely on peer-reviewed journal articles thus missing potential insights, however several papers lacked the breadth and depth of analysis expected from more rigorous empirical research. Adopting a broad definition of 'impact/outcome' in the review inclusion criteria may have limited the depth of the current review. Future reviews may choose to exercise more exclusive inclusion criteria but this will depend on the expansion of the evidence base for team formulation sessions given a lack of empirical evidence relating to the literature review question.

Employing bespoke appraisal tools whose validity and reliability has not been formally evaluated, may have limited the identification of bias within the selected studies. However these checklists (Appendices B & C) included some items from recognised appraisal tools and showed promise in differentiating between studies based on their methodological quality, whilst the quality score (Table 1.4) is a succinct reflection of this. Neither the screening/eligibility assessment process, nor critical appraisal of articles was verified with another reviewer. This limits the reliability of the results, however the search strategy, screening process and critical appraisal process has been presented transparently within the current review and is therefore replicable.

Synthesising findings using a thematic approach enabled the findings reported by various methodologies to be compared and contrasted. Triangulating results in this way helped to avoid overstating the impact of team formulation, thus providing a more valid and reliable appraisal of the literature (Golafshani, 2003).

## **CONCLUSION**

In conclusion, the critical review and synthesis of empirical and practice-based evidence for team formulation identified key themes, indicating the impact of this approach at different levels of mental health services. Findings support the use of team formulations in mental health services insofar as helping developing staff-service user alliances and improving the team climate, yet there were no direct clinical benefits to service users. Reviewed studies were of varying quality, mainly limited by lack of rigour during analysis. Further enquiry into the conditions under which staff and service users benefit from team formulations, and what aspects are most valued about such meetings, is warranted to help refine and develop sessions to maximise their utility and benefits.

## REFERENCES

- Aston, R. (2009). A literature review exploring the efficacy of case formulations in clinical practice: What are the themes and pertinent issues? *The Cognitive Behaviour Therapist*, 2, 63-74. doi: 10.1017/S1754470X09000178.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: Meridian.
- Berry, K., Barrowclough, C., & Wearden, A. (2009). A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behavioural & Cognitive Psychotherapy*, 37, 39-48. doi: 10.1017/S1352465808005018
- Berry, K., Haddock, G., Kellett, S., Roberts, C., Drake, R., & Barrowclough, C. (2015). Feasibility of a ward-based psychological intervention to improve staff & patient relationships in psychiatric rehabilitation settings. *British Journal of Clinical Psychology*. doi: 10.1111/bjc.12082
- Bieling, P. J., & Kuyken, W. (2003). Is cognitive case formulation science or science fiction? *Clinical Psychology: Science & Practice*, 10, 52-69. doi: 10.1093/clipsy.10.1.52
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), 77-101. doi: 10.1191/1478088706qp063oa
- Carmeli, A., Brueller, D., & Dutton, J.E. (2009). Learning behaviours in the workplace: The role of high-quality interpersonal relationships and psychological safety. *Systems Research & Behavioural Science*, 26, 81-98. doi: 10.1002/sres.932
- Carradice, A. (2013). Five session CAT consultancy: Using CAT to guide care planning with people diagnosed with PD within CMHTs. *Clinical Psychology & Psychotherapy*, 20, 359-367. doi: 10.1002/cpp.1812
- Critical Appraisal Skills Programme (2013a). *CASP Randomised Controlled Trial Checklist*. Retrieved from [http://media.wix.com/ugd/dded87\\_40b9ff0bf53840478331915a8ed8b2fb.pdf](http://media.wix.com/ugd/dded87_40b9ff0bf53840478331915a8ed8b2fb.pdf)
- Critical Appraisal Skills Programme (2013b). *CASP Qualitative Checklist*. Retrieved from [http://media.wix.com/ugd/dded87\\_29c5b002d99342f788c6ac670e49f274.pdf](http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf)
- Charmaz, H. (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London: SAGE.
- Christofides, S., Johnstone, L., & Musa, M. (2012). 'Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary

team working. *Psychology & Psychotherapy: Theory, Research & Practice*, 85, 424-435. doi: 10.1111/j.2044-8341.2011.02041.x

Collins, A. (2011). *Exploring psychological processes in reflective practice groups in acute inpatient wards: A grounded theory study* (Unpublished doctoral dissertation). Canterbury Christ Church University, Tunbridge Wells.

Craven-Staines, S., Dexter-Smith, S., & Li, K. (2010). Integrating psychological formulations into older people's services – three years on (Part 3): Staff perceptions of formulation meetings. *PSIGE Newsletter*, 112, 16-22.

Division of Clinical Psychology (2010). *The core purpose and philosophy of the profession*. Leicester: BPS.

Division of Clinical Psychology (2011). *Good practice guidelines on the use of psychological formulation*. Leicester: BPS.

Department of Health (2007). *Mental Health: New Ways of Working for Everyone*. London: DoH.

Dexter-Smith, S. (2007). Integrating psychological formulations into inpatient services. *PSIGE Newsletter*, 97, 38-42.

Dexter-Smith, S. (2010). Integrating psychological formulations into older people's services: Three years on (Part 1). *PSIGE Newsletter*, 112, 8-11.

Dollard, M.F. & bakker, A.B. (2010). Psychosocial safety climate as a precursor to conducive work environments, psychological health problems, and employee engagement. *Journal of Occupational & Organisational Psychology*, 83, 579-599. doi: 10.1348/096317909X470690

Downs, S.H., & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiology & Community Health*, 52, 377-384. doi: 10.1136/jech.52.6.377

Dudley, R., & Kuyken, W. (2006). Formulation in cognitive behavioural therapy. In L. Johnstone and R. Dallos (Eds.), *Formulation in Psychology & Psychotherapy* (pp. 17-46). Routledge: Oxford.

Edmondson, A.C. & Lei, Z. (2014). Psychological safety: The history, renaissance, and future of an interpersonal construct. *Annual Review of Organisational Psychology & Organisational Behaviour*, 1, 23-43. doi: 10.1146/annurev-orgpsych-031413-091305

Elliott, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215–229. doi: 10.1348/014466599162782

- Elo, S., & Kyngas, H. (2008). The qualitative analysis process. *Journal of Advanced Nursing*, 62 (1), 107-115. doi: 10.1111/j.1365-2648.2007.04569.x
- Emmelkamp, P. M. G., Bouman, T. K. & Blaauw, E. (1994). Individualized versus standardized therapy: A comparative evaluation with obsessive-compulsive patients. *Clinical Psychology & Psychotherapy*, 1, 95–100. doi: 10.1002/cpp.5640010206
- Flinn, L., Braham, L., & das Nair, R. (2015). How reliable are case formulations? A systematic literature review. *British Journal of Clinical Psychology*, 54, 266–290. doi: 10.1111/bjc.12073
- Freedman, J., & Combs, G. (1996). *Narrative Therapy: The social construction of preferred realities*. New York: Norton.
- Garson, G.D. (2014). *Path Analysis* [Kindle DX version]. Retrieved from [http://www.amazon.co.uk/Path-Analysis-Statistical-Associates-Blue-ebook/dp/B0093GKTKS?ie=UTF8&keywords=path%20analysis&qid=1461520943&ref\\_=sr\\_1\\_2&s=books&sr=1-2](http://www.amazon.co.uk/Path-Analysis-Statistical-Associates-Blue-ebook/dp/B0093GKTKS?ie=UTF8&keywords=path%20analysis&qid=1461520943&ref_=sr_1_2&s=books&sr=1-2)
- Golafshani, N. (2003). Understanding reliability & validity in qualitative research. *The Qualitative Report*, 8 (4), 597-606.
- Goldberg, D.P., & Hillier, V.F. (1979). A scaled version of the General Health Questionnaire. *Psychological Medicine*, 9 (1), 139-145. doi: <http://dx.doi.org/10.1017/S0033291700021644>
- Gumley, A. & Park, C. (2010). Relapse prevention in early psychosis. In P French, J. Smith, D. Shiers, M. Reed, & M. Rayne (Eds.), *Promoting recovery in early psychosis: A practice manual* (pp.157-167). Chichester: Blackwell.
- Haynes A.N., & Williams A.E. (2003). Case formulation & design of behavioural treatment programs. *European Journal of Psychological Assessment*, 19, 164–174. doi: <http://dx.doi.org/10.1027//1015-5759.19.3.164>
- Health Care Professions Council (2015). *Standards of proficiency: Practitioner psychologists*. London: HCPC. Retrieved from [http://www.hpc-uk.org/assets/documents/10002963sop\\_practitioner\\_psychologists.pdf](http://www.hpc-uk.org/assets/documents/10002963sop_practitioner_psychologists.pdf)
- Herhaus, J. K. (2014). *Constructing shared understanding: A grounded theory exploration of team case formulation from multiple perspectives* (Unpublished doctoral dissertation). University of Glasgow, Glasgow.
- Hewitt, M. (2008). Using psychological formulation as a means of intervention in a psychiatric rehabilitation setting. *International Journal of Psychosocial Rehabilitation*, 12 (1), 21-31.

- Ho, P.M., Peterson, P.N., & Masoudi, F.A. (2008). Evaluating the evidence: Is there a rigid hierarchy? *Circulation*, 118, 1675-1684. doi: 10.1161/CIRCULATIONAHA.107.721357
- Hood, N., Johnstone, L., & Christofides, S. (2013). The hidden solution? Staff experiences, views and understanding of the role of psychological formulation in multi-disciplinary teams. *Journal of Critical Psychology, Counselling & Psychotherapy*, 13 (2), 107-116.
- Ingham, B. (2011). Collaborative psychosocial case formulation development workshops: A case study with direct care staff. *Advances in Mental Health & Intellectual Disabilities*, 5 (2), 9-15. doi: 10.5042/amhid.2011.0107
- Ingham, B.J., Clarke, L., & James, I. (2008). Biopsychosocial case formulation for people with intellectual disabilities and mental health problems: A pilot study of a training workshop for direct care staff. *British Journal of Developmental Disabilities*, 106, 41-54. doi: 10.1179/096979508799103323
- Ingham, B., Selman, M., & Clarke, L. (2011). Biopsychosocial formulation-based working in in-patient learning disabilities services: A survey evaluation. *Clinical Psychology & People with Learning Disabilities*, 9 (2&3), 62-66.
- Jacobson, N.S., Schmalings, K.B., Holtzworth-Munroe, A., Katt, J.C., Wood, L.F., & Follette, V.M. (1989). Research-structured vs. clinically flexible versions of social learning-based family therapy. *Behavior Research & Therapy*, 27, 173-180. doi:10.1016/0005-7967(89)90076-4
- Johnstone, L. (2014). Using formulation in teams. In L. Johnstone & R. Dallos (Eds.) (2006). *Formulation in Psychology & Psychotherapy: Making Sense of People's Problems* (2<sup>nd</sup> ed.) (pp. 216-242). Oxford: Routledge.
- Johnstone, L. & Dallos, R. (Eds.) (2006). *Formulation in Psychology & Psychotherapy: Making Sense of People's Problems*. Oxford: Routledge.
- Joint Commissioning Panel for Mental Health (2013). *Guidance for commissioners of community mental health services*. Retrieved from <http://www.jcpmh.info/resource/guidance-for-commissioners-of-community-specialist-mental-health-services/>
- Kellett, S., Wilbram, M., Davis, C., & Hardy, G. (2014). Team consultancy using cognitive analytic therapy: A controlled study in assertive outreach. *Journal of Psychiatric & Mental Health Nursing*, 21, 687-697. doi: 10.1111/jpm.12123
- Lake, N. (2008). Developing skills in consultation 2: A team formulation approach. *Clinical Psychology Forum*, 186, 18-24.
- Maslach, C., & Jackson, S.E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, 2, 99-113. doi: 10.1002/job.4030020205

- Murphy, S. A., Osborne, H., & Smith, I. (2013). Psychological consultation in older adult inpatient settings: A qualitative investigation of the impact on staff's daily practice and the mechanisms of change. *Aging & Mental Health*, 17 (4), 441-448. doi: 10.1080/13607863.2013.765829
- National Institute for Health and Care Excellence (2009). *Borderline personality disorder: Recognition and management* (CG78). Retrieved from <https://www.nice.org.uk/guidance/cg78>
- National Institute for Health and Care Excellence (2014). Psychosis and schizophrenia in adults: Prevention and management (CG178). Retrieved from <https://www.nice.org.uk/guidance/cg178>
- National Institute for Health and Care Excellence (2016). *Depression in adults: Recognition & management (update)* (CG90). Retrieved from <https://www.nice.org.uk/guidance/cg90>
- Onyett, S. (2007). *New ways of working for applied psychologists in health and social care: Working psychologically in teams*. Leicester: BPS.
- Redhead, S., Johnstone, L., & Nightingale, J. (2015). Clients' experiences of formulation in cognitive behaviour therapy. *Psychology & Psychotherapy: Theory, Research & Practice*, 88, 453-467. doi: 10.1111/papt.12054
- Roe, D., Yanos, P. T., & Lysaker, P. H. (2006). Overcoming barriers to increase the contribution of clinical psychologists to work with persons with severe mental illness. *Clinical Psychology*, 13 (4), 376-383. doi: 10.1111/j.1468-2850.2006.00051.x
- Ryle, A. (2004). The contribution of cognitive analytic therapy to the treatment of borderline personality disorder. *Journal of Personality Disorders*, 18, 3-35. doi: 10.1521/pedi.18.1.3.32773
- Schulte D, Kunzel R, Pepping G, & Schulte-Bahrenburg T (1992). Tailor-made versus standardised therapy of phobic patients. *Behavioural Research and Therapy*, 14, 67-92. doi:10.1016/0146-6402(92)90001-5
- Schulz, K.F., & Grimes, D.A. (2002). Blinding in randomised trials: Hiding who got what. *Lancet*, 359, 696-700.
- Summers, A. (2006). Psychological formulations in psychiatric care: Staff views on their impact. *Psychiatric Bulletin*, 30, 341-343. doi: 10.1192/pb.30.9.341
- Tourangeau, R., & Yan, T. (2007). Sensitive questions in surveys. *Psychological Bulletin*, 133 (5), 859-883. doi: 10.1037/0033-2909.133.5.859
- Wainwright, N., & Bergin, L. (2010). Introducing psychological formulations in acute older people's inpatient mental health ward: A service evaluation of staff views. *PSIGE Newsletter*, 112, 38-45.



- Walford, G., Tucker, E., & Viswanathan, M. (Eds.) (2010). *The SAGE Handbook of Measurement*. London: SAGE.
- Wilcox, E. (2013). Biscuits & perseverance: Reflections on supporting a community intellectual disability team to reflect. *Advances in Mental Health & Intellectual Disabilities*, 7 (4), 211-219. doi: 10.1108/AMHID-03-2013-0022
- Willig, C. (Ed.) (2013). *Introducing qualitative research in psychology (3<sup>rd</sup> ed.)*. Maidenhead: Open University Press.
- Young, J. M., & Solomon, M. J. (2009). How to critically appraise an article. *Nature Clinical Practice Gastroenterology & Hepatology*, 6 (2), 82-91. doi: 10.1038/ncpgasthep1331

## APPENDICES

### Appendix A

Further details regarding exact search terms, operators, and limits used within databases.

Source	Search strategy
EBSCOhost	("Formulat*" OR "Conceptuali?ation" OR "Psycholog* Consult*") N10 ("Team" OR "Group" OR "Meeting" OR "Session") AND ("Mental Health" OR "Psychiatr*") AND (Impact OR Outcome OR Effect* OR Evaluati* ) NOT ("Cultural Consultation" OR "Cultural Formulation" OR Drug*)  <i>[Limiters: 2007-2015, English, Academic Journals &amp; Dissertations]</i>
Web of Science Core Collection	(Topic=(Formulat* NEAR/10 Team) OR Topic=(Formulat* NEAR/10 Group) OR Topic=(Formulat* NEAR/10 Meeting) OR Topic=(Formulat* NEAR/10 Session) NOT Topic=("Cultural Formulat*")) OR (Topic=(Conceptuali?ation NEAR/10 Team) OR Topic=(Conceptuali?ation NEAR/10 Group) OR Topic=(Conceptuali?ation NEAR/10 Meeting) OR Topic=(Conceptuali?ation NEAR/10 Session)) OR (Topic=("Psycholog* Consult*") NOT Topic=("Cultural Consult*")) AND (Topic=("Mental Health" OR Psychiatr*) NOT Topic=(Drug*)) AND (Topic=( Impact OR Outcome OR Effect* OR Evaluati*))

*[Limiters: 2007-2015, English]*

Cochrane Library (Title, Abstract, Keywords) “Formulation” AND (Title, Abstract, Keywords) “Team” AND (Title, Abstract, Keywords) “Outcome”

*[Expanders: ‘Word variations have been searched’; Limiters: 2007-2015]*

British Library EThOS “Psychology Formulation Team”

*[Limiters: 2007-2015, English]*

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## **Appendix B**

### **Critical appraisal tool for quantitative studies**

#### **QUANTITATIVE STUDIES**

***(Based on CASP's (2013) RCT checklist; Young & Solomon's (2009) guide to critical appraisal; and Downs & Black's (1998) checklist for critically appraising randomised and non-randomised studies)***

1. Did the study address a clearly focused issue?
2. (i) Was the study design appropriate for the research question?
  - (ii) Was a control group used?
3. (i) Was the recruitment strategy appropriate?
  - (ii) Were participants adequately described?
  - (iii) Were participants representative of the population from which they were drawn?
4. (i) Where relevant, were participants properly randomised into experimental groups?
  - (ii) Were experimental groups similar at the start of the study?
5. (i) Is the intervention (IV) clearly described?
  - (ii) Is sufficient detail provided to replicate?
  - (iii) Where relevant, were groups treated equally aside from the experimental intervention?
6. (i) Were the relevant outcomes accurately assessed?
  - (ii) Were outcomes/OMs clearly defined, valid and reliable?
  - (iii) Where relevant, was 'blinding' used (e.g. were assessors 'blinded' to participants' experimental group)?
7. (i) Was the data analysed appropriately?
  - (ii) Did the study have sufficient power to detect a clinically important effect?
8. (i) Were the results presented appropriately?
  - (ii) Do the data justify the conclusions?
  - (iii) Where relevant, is the effect size stated (and CIs)?
  - (iv) Have actual probability values been reported?
  - (v) Were all participants accounted for in the final analysis?
9. Were ethical issues considered?
10. Did the study state where it fits within the relevant literature?
11. Are findings discussed in terms of their implications for clinical practice?

## **Appendix C**

Critical appraisal tool for qualitative studies

### **QUALITATIVE STUDIES**

***(Based on Elliott, Fischer & Rennie's (1999) guidelines for appraising qualitative research; and CASP's (2013) Qualitative Research checklist)***

1. Is there a clear statement of the aims of the research?
2. Was a qualitative methodology appropriate?
3. Have ethical issues been considered?
4. (i) Was the recruitment strategy appropriate?
  - (ii) Are participants adequately described in terms of relevant characteristics, circumstances or context?
  - (iii) Is there a discussion of why participants were the most appropriate to provide access to the type of knowledge sought by the study?
5. (i) Was the data collection process/method clear?
  - (ii) Is enough information provided so that the study could be replicated (e.g. interview schedules)?
6. (i) Was the data analysed with sufficient rigour?
  - (ii) Are examples of the analytical process provided?
  - (iii) Is it clear how categories/themes/accounts were derived from the data?
  - (iv) Is sufficient data presented to support the findings (e.g. examples given to illustrate themes)?
  - (v) Has the relationship between the researcher and the research process been adequately considered?
7. (i) Is there a clear statement of findings?
  - (ii) Are qualitative findings discussed in relation to the original research issue/aims?
  - (iii) Were the findings checked for credibility (e.g. multiple coding, respondent validation, triangulation)?
8. Did the study state where it fits within the relevant literature?
9. Are findings discussed in terms of their implications for clinical practice?

## Appendix D

### Quantitative scoring sheet for critical appraisal tool

	Q1	Q2		Q3			Q4		Q5			Q6			Q7		Q8					Q9	Q10	Q11	Quality Score
		i	ii	i	ii	iii	i	ii	i	ii	iii	i	ii	iii	i	ii	i	ii	iii	iv	v				
Berry et al. (2009)	Y	Y	N	Y	Y	Y	NA	NA	Y	Y	NA	Y	Y	NA	Y	N	Y	Y	NA	Y	Y	P	Y	Y	16.5/19
Berry et al. (2015)	Y	Y	Y	Y	Y	P	P	DK	Y	Y	DK	Y	Y	Y	Y	DK	Y	Y	Y	Y	Y	Y	Y	Y	20/24
Ingham (2011)	Y	P	NA	Y	P	DK	NA	NA	Y	Y	NA	P	P	NA	P	NA	Y	P	NA	NA	DK	DK	Y	P	9.5/16
Ingham et al. (2011)	Y	Y	N	Y	P	DK	NA	NA	Y	Y	NA	Y	P	NA	Y	NA	Y	Y	NA	NA	DK	DK	N	Y	11/17
Kellett et al. (2014)	Y	Y	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	DK	Y	DK	Y	Y	Y	Y	DK	Y	Y	P	20/24
Wilcox (2013)	P	P	N	P	P	DK	NA	NA	Y	P	NA	P	P	NA	NA	NA	P	P	NA	NA	NA	Y	N	P	7/15

Note. *Italics*=mixed methods study; Y=yes, N=no, DK=don't know, NA=not applicable, P=partly (i.e. the question was addressed to an extent but could have been elaborated upon); Scoring: Y=1 point, P=0.5 points, N=0 points, DK=0 points.

## Appendix E

### Qualitative scoring sheet for critical appraisal tool

	Q1	Q2	Q3	Q4			Q5		Q6					Q7			Q8	Q9	Quality Score
				i	ii	iii	i	ii	i	ii	iii	iv	v	i	ii	iii			
Collins (2011)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	P	Y	17.5/18
Craven-Staines et al. (2010)	Y	Y	Y	N	Y	N	Y	Y	DK	N	N	Y	P	Y	Y	P	N	P	10.5/18
Herhaus (2014)	Y	Y	Y	Y	P	P	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	17/18
Murphy et al. (2013)	Y	Y	Y	Y	Y	P	Y	P	Y	N	Y	Y	Y	Y	Y	P	Y	P	15/18
Wainwright & Bergin (2010)	Y	Y	DK	DK	P	N	Y	Y	DK	P	N	P	P	P	Y	N	N	Y	8.5/18
<i>Ingham (2011)</i>	NA*	P	NA*	NA*	NA*	NA*	Y	NA*	N	N	NA	P	N	P	Y	N	NA*	NA*	3.5/9
<i>Ingham et al. (2011)</i>		Y					Y		P	N	Y	P	N	Y	Y	P			6.5/10
<i>Kellett et al. (2014)</i>		Y					Y		Y	Y	P	Y	P	Y	Y	P			8.5/10
<i>Wilcox (2013)</i>		N					Y		N	N	NA	P	P	Y	P	N			3.5/9

Note. *Italics*=mixed methods study; Y=yes, N=no, DK=don't know, NA=not applicable, NA\*=not applicable as item duplicates quantitative ratings for mixed methods studies, P=partly (i.e. the question was addressed to an extent but could have been elaborated upon); Scoring: Y=1 point, P=0.5 points, N=0 points, DK=0 points.





## **Chapter 2: Research Report**

**Psychological Formulation in Residential Teams Working with People with Dementia: An Exploration of Multidisciplinary Views using Q-methodology.**

## ABSTRACT

Group formulation sessions aspire to develop a shared understanding of an individual, presenting problems and unmet needs, which thereafter guides the team's intervention (Johnstone, 2014). They are increasingly delivered in dementia care settings, yet little is known about how they are perceived or the outcomes of this approach. This study used Q-methodology to explore the viewpoints on formulating with teams in residential dementia care. Seventeen multidisciplinary staff, who had either facilitated or contributed to formulations, participated in a statement sorting task and semi-structured interview. Factor analysis helped identify three shared accounts concerning the aspects that were most highly valued: (1) *Working together to identify residents' unmet needs*, (2) *Prioritising the needs of the resident versus those of the team*, (3) *Being heard – Valuing the relationship between the facilitating clinician and team*. Findings may relate to participants' different levels of training and organisational influences. Clinical and research implications are also discussed.

**Keywords:** Challenging Behaviour, Dementia, Formulation, Multidisciplinary.

Abstract word count: 150 / 150

Paper 2 word count (excluding references): 7,753 / 8,000

## INTRODUCTION

Psychological formulation is a core skill for clinical psychologists, and refers to developing a detailed account explaining why an individual has come to experience mental health difficulties based on their personal history, psychological theory and research (Division of Clinical Psychology (DCP), 2011). Formulations should summarise the client's presenting issues, suggest how these difficulties relate to one another, and offer a perspective concerning the development and maintenance of such problems which thereafter guides the path of appropriate interventions (Johnstone & Dallos, 2006). Whilst formulation comprises a key aspect of psychological therapy with individual clients (for reviews see: Aston, 2009; Rainforth & Laurensen, 2014), its application is not limited to such contexts.

### *Psychological formulation with multidisciplinary teams*

The 'New Ways of Working' initiative (Department of Health (DoH), 2007) outlined the need for mental health professionals to work collaboratively and efficiently to provide effective care to service users. A key recommendation involved senior team members acting as supervisors and consultants within their existing teams. Onyett (2007) identified that through using formulation during peer consultation, clinical psychologists could add value to the multidisciplinary team working whilst still retaining their unique professional identity (e.g. counterbalancing traditional medical models of mental health).

The practice of psychological formulation in teams is recommended by professional practice guidelines (DCP, 2010, 2011; Health and Care Professions Council (HCPC), 2015). It is supported by multiple studies and evaluations of practice within community mental health teams (cf. Christofides, Johnstone & Musa, 2012; Hood, Johnstone & Christofides, 2013) and inpatient wards (cf. Berry, Barrowclough & Wearden, 2009; Robson & Quayle, 2009). However, there has been little investigation regarding its use or impact in other settings.

Formulating with teams has been associated with a number of positive effects (for a more comprehensive review, see Paper 1). These include supporting staff to develop empathic working relationships with service users (Berry et al., 2015;

Collins, 2011), disseminating clinical information and skills (Collins, 2011; Kellett, Wilbram, Davis & Hardy, 2014), improving team efficiency (Lake, 2008) and sense of cohesion (Davenport, 2002).

This clinical approach may be especially pertinent in services working with people presenting with complex biopsychosocial needs, requiring a coordinated and consistent approach to care, such as older adults with dementia living in residential care (Jackman, Fielden & Pearson, 2015; Onyett, 2007).

However, research has yet to identify direct clinical benefits to service users (Berry et al., 2015; Kellett et al., 2014). Whilst several ward staff agreed that team formulation sessions helped understand and manage older adults' complex needs more effectively, some staff expressed critical views of the approach, stating that it lacked relevance for service users with an underlying organic impairment (Dexter-Smith, 2010; Murphy, Osborne & Smith, 2013), and would benefit from greater involvement of relatives and non-qualified staff (Craven-Staines, Dexter-Smith & Li, 2010; Wainwright & Bergin, 2010).

#### *Team formulation in dementia care*

Dementia is a group of acquired brain disorders typically characterized by neurodegenerative changes resulting in deterioration in functioning (World Health Organisation, 1992). The impact of the condition on an individual's behaviour, functioning and quality of life is also influenced by their personal biography, quality of interactions, and social context (Kaufman & Engel, 2014; Nowell, Thornton & Simpson, 2011; O' Connor et al., 2007; Smebye & Kirkevold, 2013). People with dementia (PWD) can experience a range of mental health difficulties that cause significant distress for both the individual and their carers, such as depression, anxiety or hallucinations. Some PWD can behave in ways that challenge services, conceptualised by Cohen-Mansfield (2000) as reflecting an effort to either communicate or directly fulfill a need that is unmet, and/or as a sign of frustration.

Staff working in residential home settings for older adults with dementia often experience significant barriers to effective and efficient team working practices, due to low staffing levels, burnout, and a lack of emotional support when caring for

clients with complex needs (Duffy, Oyebode & Allen, 2009; Murphy et al., 2013). Organisational and social environments arising within this challenging context can maintain unhelpful systems of care, requiring a whole-team approach to successful intervention based on a shared understanding of the presenting issues (James, 2011).

Whilst the National Institute for Health and Care Excellence (NICE, 2006) recognise the value of personalized psychological interventions (for a review see Testad et al., 2014), the mechanisms by which clinicians translate the information gathered during assessment into decisions regarding care planning and effective interventions are absent from clinical guidelines (Jackman, Wood-Mitchell & James, 2014).

Increasingly team-based formulations are being utilised within residential home settings for PWD whose behaviour challenges, as a way of collaboratively identifying complex needs and tailoring individualized care plans. The Newcastle Model (James, 1999) is one such approach; this involves a discrete formulation session during which a facilitator (usually a psychologist) works closely with a group of carers to develop hypotheses about what the PWD might be thinking and feeling during episodes of challenging behaviour, through sharing information about their life, experiences, mental and physical health. In addition to the content of such sessions, several authors have outlined the importance of the clinician's therapeutic skills in facilitating this process effectively, such as the use of specific questioning styles and reflections (Jackman et al., 2014), strengthening working relationships within teams (Shirley, 2010), and helping the group feel safe to disclose salient issues (Jackman et al., 2015).

Wood-Mitchell, Mackenzie, Stephenson and James (2007) report that this model can be effective at reducing the frequency and severity of challenging behaviour and staff distress. Whilst respondents consistently rated the formulation session as the most helpful aspect of this model (Mackenzie & James, n.d.), research has yet to identify which aspects of the formulation were valued most.

Exploring the views of those involved in team formulation concerning the valued aspects of such sessions, and the extent to which these are shared between disciplines is prudent given the importance of collaborative working between facilitating clinicians and staff teams (James, 2011; Onyett, 2007).

## **Rationale**

Research concerning the use of formulation within multidisciplinary teams is limited to inpatient and community mental health settings. Despite the popularity of this clinical model (James, 2011), the evidence for a team formulation approach and its impact in residential care settings for PWD is less clear. The limited literature exploring views on team formulation to date comprises several service evaluations using semi-structured interviews (e.g. Craven-Staines et al., 2010; Wainwright & Bergin, 2010). This somewhat limits the validity of findings due to the potential for socially desirable views to be more readily expressed (Tourangeau & Yan, 2007). Paradoxically, the views of the main participants in team formulations (i.e. non-professional staff and facilitating clinicians) on this topic are currently under represented (Craven-Staines et al., 2010).

These limitations have clinical, practical and ethical implications. Formulation-led approaches are more resource intensive than standardized protocols (DCP, 2011), and continued practice of unhelpful approaches inevitably postpones access to effective interventions for people experiencing significant distress. Further research exploring what multidisciplinary clinical staff value in team formulation sessions may inform the development of evidence-based psychological approaches to supporting residential teams to deliver effective person-centred care for PWD.

In an effort to overcome some of the limitations in the current paucity of existing literature regarding the use of team formulation, this study seeks to apply a rigorous methodology to reveal significant viewpoints through statistical and qualitative interpretation.

**Aims**

The current study will examine the extent to which mental health professionals and residential staff teams share beliefs about the various aspects of team formulation sessions in care/nursing settings for PWD. Q methodology will be applied to explore the prominent viewpoints on this topic and consider why these perspectives may have emerged.

## METHOD

### **Q methodology: An Overview**

Q methodology was developed by Stephenson (1953, cited in Watts & Stenner, 2012) as a means of investigating the subjective views that exist in relation to a particular topic. Quantitative and qualitative methods are applied to systematically identify and attempt to understand the patterns and relationships between these viewpoints (Shinebourne, 2009; van Excel & de Graaf, 2005).

Participants are asked to rank order a selection of statements (the Q set) according to their view on the topic being studied, typically ranging from strongly agree (+5) to strongly disagree (-5). The ranking process (or *condition of instruction*) uses a forced choice paradigm, whereby each space on the quasi-normal distribution should be occupied by one statement from the Q set. It is by performing these relative evaluations between statements (*Q sort*) that participants give meaning to the Q set and thus reveal their subjective viewpoint (Smith, 2001). Participants' Q sorts are correlated with one another, subjected to a factor analysis and interpreted by the researcher to identify and understand participants' shared viewpoints (Shinebourne, 2009; van Excel & de Graaf, 2005).

### **Epistemological Position**

The researcher subscribes to a social constructionist position that knowledge and meaning are constructed iteratively between an individual and their sociocultural context. Therefore, an array of viewpoints exist in relation to a topic of interest. This is in opposition to the realist premise that there is an obtainable empirical truth or reality that can be measured (Schwandt, 2000).

The researcher is a trainee clinical psychologist with an interest in working systemically with multidisciplinary teams. His professional culture, clinical experience, and beliefs concerning the use of formulation within residential dementia services will have affected the items in the Q set and the factor interpretation. Although this is consistent with his epistemological beliefs that meaning is co-constructed, efforts were made to limit the researcher's influence on



the Q set and participants' Q sorts by approaching the following steps with methodological rigour.

### **Stage 1: Producing the Q set**

The primary research instrument of Q methodology is the Q set. This refers to a subset of statements that broadly represent the *concourse* or range of opinions that have been expressed surrounding the topic of interest. A Q set of between 40-80 items is suggested to avoid overwhelming participants whilst maintaining adequate coverage of the concourse (Stainton Rogers, 1995). Refining the Q set should be approached with rigour to minimise bias (Watts & Stenner, 2012).

Multiple sources were used to establish a comprehensive appraisal of the factors deemed important when formulating with residential teams working with people with dementia. The researcher facilitated two focus groups involving psychologists ( $n=6$ ) and a residential nursing care team ( $n=5$ ) specializing in working with older adults with dementia, who were invited to discuss their respective views on the topic under investigation and gave their consent to this effect (Appendices F & G). Statements were also generated from academic literature. This identified 211 potential statements. Duplicates were removed and similar items collapsed leaving 71 and 56 statements, respectively. An academic supervisor corroborated this refinement process. A clinical psychologist and three trainee psychologists with knowledge of Q methodology scrutinized the remaining 56 statements for repetition, grammatical and typographical errors, resulting in minor changes to the phrasing of some items. The Q set was piloted with a psychologist with experience of using team formulation, to check the statements were understandable and to confirm the condition of instruction. This resulted in rephrasing one statement and amending the condition of instruction. The final statements were each randomly assigned a number to aid data analysis.

### **Stage 2: Conducting the Q Sorts**

#### ***Ethical Approval***

The research procedure was reviewed and approved by Staffordshire University's Research Ethics Committee (REC; Appendix H). Approval was also obtained from the clinical psychologists' employing NHS Foundation Trust (Appendix I).

## ***Participants***

There is no consensus on the sample size of a Q methodological study. A salient viewpoint may of course emerge from a single participant (Watts & Stenner, 2005), although factors may be more likely to be revealed in samples of between 40-60 (Stainton Rogers, 1995). Q methodological studies have achieved respectable accounts of the variance in participants' viewpoints using much fewer participants (e.g. Ahmed, 2013; Seel, 2008; Williams, 2013), and research has been successfully published using smaller samples ( $N=16$ ; Combes, Hardy & Buchanan, 2008). Q methodology positively embraces studies using limited participant numbers since patterns can still emerge whilst retaining a focus on qualitative aspects of responses (Watts & Stenner, 2005, 2012).

A strategic sampling approach was taken to identifying participants likely to hold a variety of perspectives on the topic of formulating with residential teams in dementia services.

All participants were required to be fluent and literate in English, and over the age of 18 years. The sample included:

- Qualified and non-qualified staff currently employed in nursing/residential homes for people with dementia, who had either recently participated in a formulation meeting (i.e. in the past 4 months) or attended at least two formulation meetings.
- Clinical psychologists who were either qualified or in doctoral training, and had facilitated or supervised at least one formulation meeting with a residential/nursing staff team working with people with dementia in the past 12 months.

The two participant groups were recruited differently due to their separate employers. Residential/nursing home staff and managers were recruited through their place of employment. Staff teams who met the study's inclusion criteria were identified and contacted by a clinical psychologist through their place of employment with information about the study (Appendix J); the author subsequently engaged those expressing an interest in participating. Clinical

psychologists were recruited through their employing NHS Trust (qualified) and academic institution (trainees), an email invitation (Appendix K) and word of mouth.

17 participants took part in the Q sort study: 5 residential staff members, 10 clinical psychologists, and 2 other mental health professionals (Appendix L).

### ***Setting***

The Q-Sorts were completed in private rooms at participants' place of work, namely across a number of independent sector residential/nursing homes, NHS mental healthcare teams, and at Staffordshire University.

### ***Materials***

The materials included: the participant information sheet (Appendix J), consent form (Appendix M), a set of self-report pre-sorting questions (Appendix N), the Q-Set (56 statements, Appendix O), a Q-sort distribution matrix which also displayed the condition of instruction (Appendix P), a post-sort interview schedule (Appendix Q), and a debrief sheet (Appendix R).

### ***Procedure***

Individuals who expressed an interest in participating in the study were provided with an information sheet and given an opportunity to ask the researcher questions. Each participant was then asked to read and sign a consent form, and to provide some demographic details and descriptive information regarding their experience of team formulation meetings.

Participants were then presented with the Q-Set (56 statements), asked to read each item, and then assign it to one of three categories: 'agree', 'disagree', and 'neutral' depending on their initial reaction to the statement. Participants then completed an individual Q-Sort by ranking the statements along a forced-choice continuum (Table 2.1) from 'most important' to 'least important' in relation to their own view of the key aspects of team formulation meetings. Participants were given an opportunity to move any of the statements to ensure they were satisfied with their sort.

Subsequently a brief post-sort interview was conducted by asking the participant a number of open-ended questions to ascertain how they had determined their Q-sort. Particular attention was paid to the extremes of the distribution (i.e. the -5 and +5 positions). After completing the interview, participants were debriefed, asked whether they had any further questions about the study, and thanked for their time.

The researcher documented responses on the interview schedule, and recorded the final statement distribution onto a response matrix once the Q-Sort was complete.

Table 2.1

*Forced choice frequency distribution.*

Ranking value	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
Number of items	2	4	5	6	7	8	7	6	5	4	2

## RESULTS

### Data Analysis

The Q methodological data analysis process seeks to identify shared viewpoints regarding a topic, through identifying and interpreting factors which explain the similarities and variation between participants' subjective Q sorts. This necessitates three methodological transitions: from Q sorts to factors using correlation and factor analysis; from factors to factor arrays by calculating the weighted averaging of significantly loading Q sorts; and from factor arrays to factor interpretations via a process of interpretation (Watts & Stenner, 2012).

#### *Q sorts to factors*

A total of 17 completed Q sorts were analysed using the dedicated computer package PQmethod (v2.35; Schmolck, 2014). This software first correlates each individual Q sort with every other Q sort, producing a 17x17 correlation matrix outlining the nature and strength of the relationships between all Q sorts (Appendix S). This matrix was then subjected to a by-person factor analysis using Principal Components Analysis. Subsequently, factors were extracted provided they had an eigenvalue of greater than 1.00 and at least two significantly loading Q sorts, known as factor exemplars. These criteria ensured that factors represented shared viewpoints regarding the topic, and explained more variance than a single Q sort according to the Kaiser-Guttman criterion (Guttman, 1954; Kaiser, 1960, 1970). Three factors were extracted from the data and subject to varimax rotation, which together explained 52% of the study variance (Table 2.2). The majority of the Q sorts (16 of 17) loaded significantly on one or other of these three factors.

Factor loadings indicate the extent to which individual Q sorts are associated with each extracted factor, expressed as a correlation. Q sorts loading significantly onto a factor are known as factor exemplars, because their individual Q sort configurations and thus viewpoints regarding the research question are similar. In the current study, Q sorts from participants 2, 4, 5, 6, 7, 9, 14, 15 and 16 loaded significantly onto factor one. The Q sorts from participants 1, 8, 10 and 13 loaded significantly onto factor two, whilst Q sorts from participants 11, 12 and 17 loaded

significantly onto factor three. Participant 3's Q sort did not load significantly onto any of the factors.

Table 2.2

*Eigenvalues and variance, before and after rotating factors.*

	Pre-Varimax		Post-Varimax	
	Eigenvalue	Variance	Eigenvalue	Variance
Factor 1	5.85	34%	4.67	27%
Factor 2	1.62	10%	1.91	11%
Factor 3	1.34	8%	2.22	13%

#### *Factors to factor arrays*

The factor exemplars were then merged to produce a single 'typical' Q sort for each factor, called a factor array, which depicted the overall viewpoint communicated by participants loading onto that particular factor. This was calculated by PQmethod using a weighted averaging procedure for Q sorts that loaded significantly onto the factor, whereby higher loading exemplars (i.e. those which better exemplify the factor) were given more importance. Factor arrays for all three factors were produced (Appendix T).

#### *Factor arrays to factor interpretations*

Factor interpretation entailed careful inspection of the configuration of items in each of the factor arrays (Appendix U). Particular attention was paid to the highest and lowest ranked items (i.e.  $\pm 5$  and  $\pm 4$  positions), alongside the distinctiveness of each item's position within one factor relative to the other factors. PQmethod provided the researcher with this information in the form of *distinguishing statements* - those items ranked significantly differently by one factor relative to the others, and *consensus statements* - items that failed to significantly distinguish between any pair of factors. The interpretation of each factor was informed by attending to the distinguishing statements placed significantly differently ( $p < .05$ ) for each array since these represented the uniqueness of that particular viewpoint, rather than the interpretation being clouded by inclusion of shared statements.

This was achieved by producing crib sheets for each factor based on guidance provided by Watts and Stenner (2012). These were integrated with the aforementioned PQmethod output regarding the statistical significance of the relative placing of statements between factors (Appendix V). Interpretations were also supported by verbal feedback from participants who loaded significantly onto the corresponding factor, collected during the post-sort interview. This method ensured the researcher engaged with each salient statement, thus aiding a holistic interpretation of each of the shared viewpoints represented by the factors.

## **Findings**

A description of each factor is presented alongside the demographic details of the participants who loaded significantly onto the factor. The rankings of relevant Q set items are cited in the interpretation, for instance (53: -4) indicates that item 53 was ranked in the -4 position in the factor array Q sort.

### ***Factor One: Working Together to Identify Residents' Unmet Needs***

Factor one has an eigenvalue of 4.67 and explains 27% of the study variance. Nine participants (2, 4, 5, 6, 7, 9, 14, 15 and 16) are significantly associated with this factor. All exemplars are female professionals; most are Psychologists (four of whom are in training, three are qualified) with experience of facilitating between 1 and 20+ team formulation meetings, and two are Nurses with experience of participating in 2 to 5 sessions.

### ***Interpretation***

This account asserted that the meeting should help the team to understand the resident's behaviour as a way of communicating an unmet need (21: +5), with the majority of exemplars stating that this was a fundamental aspect of the session (participants 4, 13 and 16) associated with developing a more humanizing view of the resident (participants 2 and 6). It was important to clearly describe exactly what happens during an episode of behaviour that challenges (33: +2). Relative to other factors, this viewpoint assigned less importance to the formulation meeting fulfilling a clinical governance role in terms of ensuring that strategies are the least restrictive option for managing a situation (42: -1) or discussing situations that

pose an immediate risk with a view to developing a management plan (34: -2) as this was within clinician's "*duty of care*" (participant 5).

The importance of obtaining background information about the resident prior to the formulation meeting (52: +5) was emphasised: "The whole point is to get to know the resident...[this enables you to] have more of an emotional attachment to them which makes you to feel more involved and connected to them as an individual" (participant 15). Other exemplars noted that the facilitator needs to have a comprehensive overview of the resident's life history, otherwise they risk losing credibility when working with the staff team caring for the resident (participants 4 and 16). However, the factor array implied that this was not necessarily the sole responsibility of the facilitator, as "*everyone [participating in the formulation meeting] should have at least some basic knowledge of the resident's past*" (participant 9). The idea that the facilitator should get to know the resident before the meeting takes place (29: -2) was given less importance in this perspective than in the other two factors.

The distinguishing statements within the current factor also suggest that participants valued collaborative working within team formulation sessions, whereby the facilitator and team should work together to develop strategies for intervention (26: +3) based on the group's feedback about whether the discussion is helpful (50: 0). Several exemplars expressed the belief that staff teams were often disenfranchised by previous unsuccessful attempts to manage behaviour that challenges, and therefore stressed the value of "*empowering*" staff to play an active role in planning interventions (participants 2, 7 and 16). It was less important for the intervention plan decided in the meeting [to be] fed-back to the resident and their family (8: -2).

In accordance with the emphasis on collaboration, the facilitator's role was perceived as needing to be less directive within team formulation meetings: exemplar participants did not feel strongly that the facilitator should help the group move on from difficult situations by discussing what can be done about it (14: -3), nor should the facilitator acknowledge when issues relating to the wider organisation come up or suggest how these will be raised elsewhere (15: -2).



Participants did not feel strongly that the meeting's facilitator should be someone outside of the care organisation (e.g. NHS clinician) (32: -4), and recognised the value of internal members of staff taking on this role: *"they [have] more authority and so are more likely to make a difference...the psychologist could train others"* (Participant 5). The account opposed the idea of the facilitator taking a directive position by giving ideas to the team about how to change things for the resident (9: -5) or verbally summarising the discussion to draw the group's attention to key information (56: -1). They did however value the role of the facilitator in reinforcing the good work and efforts that the staff team has committed to the resident's care (22: +3).

Whilst exemplars gave less priority to staff having time away from their normal duties to attend the formulation meeting (17: +2) relative to the other factor accounts, they did suggest it was valuable for the team to know that the home manager supports the meetings and their ideas (5: +2) as this *"sends a message about the importance of the work"* (participant 6).

Although item 16 was not a significant distinguishing statement for this factor, several exemplars (participants 5, 6, 7, 14 and 15) commented that having the resident's relatives and/or the team manager present during the team formulation session had often been helpful and was therefore important, with the caveat that this was decided on an individual basis as it may not always be appropriate. For example, these participants felt that the contribution of relatives could offer a richer biographical context to the individual's historical experiences, whilst the manager's presence could immediately clarify the feasibility of suggested interventions.

***Factor Two: Who is the Client? Prioritising the Needs of the Resident vs. those of the Team***

Factor two has an eigenvalue of 1.91 and explains 11% of the study variance. It is a bipolar factor, meaning that it is defined by positively and negatively loading Q sorts. Four participants (1, 8, 10 and 13) are significantly associated with this factor. Half were male, the others female. Two exemplars were Care Assistants with experience of participating in between three and seven team formulations. The remaining participants had facilitated sessions, one a Psychologist in training

who had led 2 sessions, and the other a qualified Psychologist who had completed over 20 sessions.

Whilst the majority of the exemplars loaded positively onto this factor, participant 10's Q sort captured a viewpoint that is a polar opposite of the shared perspectives of participants 1, 8 and 13. Thus two interpretations are provided for factor two concerning the viewpoints from the positive and negative poles, respectively.

### ***Viewpoint from the Positive Pole (Two+): Prioritising the Needs of the Resident through Active Care Planning***

#### ***Interpretation***

This pole was characterized by a more task-oriented view of the formulation sessions, valuing those aspects that facilitated building a bio-psychological depiction of the resident's needs to generate ideas for intervention. Factor exemplars strongly upheld the belief that the session should help the team to develop their understanding of a resident through considering the nature and impact of any past or present physical (55: +4), mental (37: +1) and/or cognitive health problems (1: +4). It was commented that the care team *"need to know a lot about the resident...background information helps recognise the resident as an individual, and problems can come from not knowing them personally"* (Participant 8).

The formulation meeting was perceived as playing an important role in facilitating the sharing of information within the team (11: +3), ensuring that interventions are the least restrictive option for managing behaviour that challenges (42: +5), and planning interventions as a team to help the resident exercise choice/control about how they spend their time (4: +1).

Participants were moderately open to unhelpful beliefs about people with dementia being challenged during meetings (45: +3), for instance, noting that it was unhelpful to allow problems to be located solely within the resident without exploring and acknowledging the role of wider systemic factors (Participant 1). Factor exemplars at the positive pole assigned less importance to items regarding

the nature of the working partnership between facilitator and care team, such as the requirement of a strong, collaborative relationship (7: -4; 36: -4; 26: -2; 2: -2; 43: -1). Verbal feedback from exemplars who had facilitated meetings noted that they treated their role as experts with caution, stating that “*you offer a theory*” (Participant 1) and “*although I’m not an expert, I have expertise to offer*” (Participant 13). Having a non-judgmental ethos to the meeting was given less importance (41: 0).

Of all the factors, this viewpoint expressed the strongest relative support for the formulation meeting being exclusively for residential/nursing staff and not managers or relatives (16: -2) and the delegation of tasks at the end of the session (46: +2).

### ***Viewpoint from the Negative Pole (Two-): Prioritising the Needs of the Team by Concentrating on Group Processes***

#### ***Interpretation***

The negative pole of factor four is a reverse configuration of the array described above, and as such had only one significantly loading Q sort. It strongly asserted that the formulation session should be facilitated by a psychologist (53: +5), whose role was to provide an expert opinion on the situation (40: +5) because they were perceived as “*more knowledgeable...[they] might see things that we don’t*” (Participant 10). Whilst the favour shown to these two items in the distribution was distinct from their ranking in all other factors, they were not statistically significant distinguishing statements. In spite of endorsing the facilitator as expert, the viewpoint also highlighted the importance of acknowledging that s/he is unlikely to have all the answers (7: +4). The factor was also characterized by valuing the interpersonal aspects of team formulation, including establishing a good relationship between the facilitator and staff team (36: +4), working on the problem and developing strategies for intervention together (7: +4; 26: +2). In contrast to the positive pole, these processes were prioritised over some common content of formulation sessions such as exploring the resident’s declining physical and mental health (1: -4; 55: -4; 37: -1). A less favourable view was taken of ensuring the allocation of specific tasks at the end of the meeting (46: -2).

In accordance with valuing the process of interprofessional cooperation, this account upheld the belief that the meeting should be repeated with different shifts of staff working with the resident (44: +5) whilst acknowledging that this was “*not always possible, [because] you need to make sure that the other residents don’t suffer from there being less staff*” (Participant 10). It was seen as important for as many staff as possible to have their views and concerns heard during the formulation session (24: +4; 27: +3; 43: +1) but in privacy (39: +3), and ideally not in the presence of the home manager or resident’s relatives (16: +2).

### ***Factor Three: Being Heard - Valuing the Relationship Between the Facilitating Clinician and the Care Team***

Factor three has an eigenvalue of 2.22 and explains 13% of the study variance. Three participants (11, 12 and 17) are significantly associated with this factor. All were females and each from a different profession, namely a Care Assistant, a Nurse, and an Occupational Therapist in training. Exemplars had participated in between 1 and 4 formulation sessions.

#### ***Interpretation***

This account favoured a good relationship between the facilitating clinician and the staff team in order for the meeting to be useful (36: +4), which included helping the group move on from difficult situations by discussing what can be done (14: +5). Participants subscribing to this perspective valued the views and concerns of those staff working closely with residents being heard (27: +3) within the context of a private meeting (39: +3) that is not dominated by a single member of staff (43: +4). It was important to exemplars that the meeting remained hopeful that the resident’s problems could begin to be addressed in their current placement (13: +3), and was facilitated by somebody external to the residential setting (32: +2) who did not impose an expert opinion (40: -4) as it was highly unlikely any one individual would “*know everything about [the resident]...the team probably know more about the person, [so] expertise is shared jointly*” (Participant 17). They were ambivalent about whether the facilitator of the formulation meeting was a psychologist (53: -1).

This account tended to rank the notion that formulation sessions are an important forum for either sharing information across the team (11: -3) less highly, acknowledging the emotional impact of working with the resident (31: -2), or reinforcing the team's good work (22: -3). A Care Assistant whose sort loaded onto this factor comment clarified *"It's nice to be told I'm doing a good job but isn't important...knowing I'm doing a good job by improving things for residents, that's important"* (Participant 11). The delegation of tasks at the end of meetings was not seen as important (46: -5) and was described by one exemplar as *"threatening...this closes people down from expressing their views"* (Participant 12). Similarly this viewpoint placed minimal importance on the team reaching a clearer understanding of the resident's neurological impairment (1: -4), hypothesising together about the resident's thought processes or internal state (6: -1; 51: -4), or the impact of important life events (19: 0). Considering how to improve the care home environment to improve wellbeing was also not prioritised within this factor (38: -4), attributed partly to the focus of the formulation being on nurturing positive interactions and relationships with residents (Participant 12).

### ***Q sorts not exemplified by any factor***

One Q sort did not load significantly onto any of the aforementioned factors, suggesting a different viewpoint on team formulation sessions in residential settings for people with dementia that was not captured by the three-factor solution. Participant 3 was a female Psychologist in training with experience of facilitating two formulation sessions. She strongly endorsed that the team needs to know that the home manager supports the meetings and their ideas (5: +5) and disagreed with the idea that the meeting should be for residential/nursing staff only (16: -5), as managers and relatives should attend. In the post-sort interview, this participant noted that her sort was based on a positive experience of having a care home manager and relatives present during the team formulation sessions that she led, and had helped overcome common organisational barriers to engaging independent care providers in this process: *"Organising meetings was the biggest barrier...having them there ensured things were possible...[there was] less hesitation as there was no middle-man checking the outcomes or strategies were practical for the home"*.

### **Consensus statements**

The study had seven consensus statements (10, 18, 20, 30, 33, 35 and 48) at a 0.05 significance level. This represents an agreement on 13% of the statements in the Q set, suggesting a degree of commonality across the otherwise distinct viewpoints of the participants in the study.

Consensus statements reflected participants valuing formulation meetings for recognising commendable aspects of staff's practice (48), and residents' positive qualities (18). Statements regarding clarifying the precise nature (33) and likely triggers (10) of behaviour that challenges were ranked towards the positive end of the distribution, indicating their relative importance across all factors. All of the viewpoints treated the idea of continuing contact between the staff team and facilitator post-session (35) neutrally within the distribution, although positively endorsed the importance of formulation sessions as providing the team with an experience of being listened to and taken seriously by another professional (30). Factors were neither strongly in favour nor against exploring the likely effects of a resident's medication during the formulation session (20).

### **Participants' experience of this Q methodological study**

Several participants remarked they had enjoyed participating in the study and welcomed being asked about their views. Presenting participants with a set of statements to sort, as opposed to a traditional interview, was seen to have benefits: *"It allowed me to think more about a lot of different aspects without needing to come up with these off the top of my head"* (Participant 2) and *"[It] makes you think about the little practical aspects that might otherwise get overlooked, such as the [formulation] framework and the clinical skills needed to engage the team"* (Participant 4). Some participants found it difficult to prioritise items in accordance with the forced-choice quasi-normal distribution; it was noted that the vast majority of items were seen as important, and that those placed in the -5/-4 positions represented either disagreement with the statement or viewing that aspect as less important relative to the others.

The majority of participants ( $n=10$ ) felt that the Q set was sufficiently broad to represent their views on the importance of different aspects of team formulation

sessions, and did not want to add any additional statements. Several participants cited additional items (i.e. aspects of formulation meetings that they feel are important) during the post-sort interview, including: various presentational aides such as using diagrams to illustrate how behaviours that challenge are maintained (Participants 1 & 5); how the team formulation process is communicated and contracted with care organisations before the meeting takes place (Participants 13 & 15); and normalizing residents' reactions to challenging and unfamiliar circumstances (Participant 16).

## DISCUSSION

This study aimed to explore a range of multidisciplinary views about team formulation sessions in care settings for PWD. It is the first to investigate the extent to which the component aspects of such meetings are prioritised differently by facilitating clinicians and residential/nursing teams. Q methodology was used to identify and interpret three factors, each representing a shared viewpoint amongst participants: 'Working together to identify residents' unmet needs'; 'Who is the client? Prioritising the needs of the resident versus those of the team'; and 'Being heard - Valuing the relationship between the facilitator and the team'.

### *Personhood in dementia*

The viewpoint portrayed by Factor One can be considered the study's dominant narrative, since this had the largest proportion of participants loaded onto it. This perspective highly valued aspects of formulation meetings that conceptualised the resident's behaviour as an expression of unmet need in accordance with contemporary clinical models of behaviour that challenges (Cohen-Mansfield, 2000; James, 1999, 2011), as well developing the care team's emotional connection with and knowledge of the resident through exploring an understanding of their life history. Similarly elsewhere, multidisciplinary ward staff reported gaining a more holistic appraisal of service users' needs in the context of their psychosocial history as a result of the team formulation (Dexter-Smith, 2010; Murphy et al., 2013; Robson & Quayle, 2009). Individuals who were most representative of Factor One had all received professional training in either clinical psychology or nursing. Their respective professional bodies both state the importance of providing compassionate care to support service users' wellbeing, based on a holistic understanding of the individual and evidence-based approaches (British Psychological Society (BPS), 2014; Nursing & Midwifery Council (NMC), 2015). Throughout their core training, nurses and psychologists are encouraged to apply theoretical knowledge to their practice, which may account for their high loading onto factor one relative to health care assistants who have not received such formal instruction and support to achieve this.



However, health care assistants also valued developing a more individualised understanding of the resident through the formulation meeting. This was expressed in Factor Two (positive pole), which prioritised understanding the needs of the resident by developing insight into the impact of their physical health and neurological impairment. Previously, Murphy et al. (2013) identified the frustrations of several non-psychologist ward staff that the role of physical health is often overlooked within formulations, leading to incomplete understandings of people's distress that are less useful when discussing service users with organic problems, namely dementia. The re-emergence of this minority perspective in the current study should not be overlooked; future meetings might pursue discussion of physical health and organic factors within the formulation as a means of engaging otherwise marginalised participants who value discussion of these aspects.

In the current study, an intimate knowledge of the resident's individuality and background was also thought to give credibility to an otherwise external facilitator. This is significant given the reliable findings that coherent groups that share a social identity, such as a staff team, may reject the legitimacy and views of those whom they perceive as outsiders, such as external professionals who facilitate formulation sessions (cf. Tajfel, 2010).

Encouragingly, all participants felt that those working with the resident should have some insight into their life history. Failure to recognise the individual contexts of people with dementia and consequent needs increases the social and emotional distance within caregiving relationships. Consequently opportunities for interpersonal relationships that preserve the resident's identity (e.g. through engagement in personally meaningful activities) are reduced, perpetuating further distress (Smebye & Kirkevold, 2013). The viewpoints of factors one and two are consistent with the notion of personhood, that is treating people with dementia as individuals with unique histories, needs, and preferences (Kitwood & Benson, 1995).

### *Supporting the team*

The residential and nursing staff in the current study work in challenging settings with individuals with complex mental and physical health needs. As such they are at risk of occupational stress (Duffy et al., 2009; Mitchell & Hastings, 2001); difficulties managing this can lead to staff coping by depersonalizing service users which compromises person-centred, empathic care (Maslach, 1982). The provision of clinical supervision and reflective practice is highly emphasised in psychologists' training (BPS, 2014); whilst guidelines recommend that nursing staff receive supervision, for non-qualified staff working in independent services the emphasis is more on managerial governance than reflecting on practice (Department of Health, Social Services & Public Safety, 2015). The majority of non-psychologist participants in this study subscribed to two viewpoints which both prioritised a facilitatory group context in which feelings invoked by the workplace could be processed with the support of peers, and minimised the importance of exploring specific biopsychosocial aspects of the resident's presentation. Specifically, Factor Two (negative pole) valued an emphasis on emotional containment and validation within the formulation session, which was hoped to involve as many staff as possible. Factor Three gave precedence to establishing a strong working relationship between the team and facilitator throughout the formulation process, so that staff would feel their concerns had been acknowledged and could begin to move towards potential solutions together. These viewpoints may have emerged in response to a perceived need for further opportunities for staff debriefing and whole-team planning in routine care. Callaby (2007) asserts that emotional support of carers is essential to preventing burnout and exhaustion. Participants' endorsements of the aforementioned perspectives (Factors Two & Three) support to this function of team formulation sessions.

This clinical approach is partially supported by findings that staff who had participated in regular team formulation meetings experienced significantly reduced levels of depersonalization, though general wellbeing was unchanged (Berry et al., 2015). Furthermore, the development of collaborative team formulations has been linked with enhanced professional working alliances with service users, in terms of renewed empathy (Collins, 2011; Herhaus, 2014) and service users experiencing less criticism from staff (Berry et al., 2015).

To summarise, participants' viewpoints regarding the different aspects of team formulation meetings emphasised the importance of: developing a shared understanding of the resident's unmet biopsychosocial needs; working collaboratively by respecting the expertise of all involved; and establishing a strong working alliance between the meeting's facilitator and the staff team to help process the impact and tasks of providing person-centred care, often in challenging circumstances. Whilst the three factors identified in this study represent shared views amongst subgroups of participants, there was a diversity of views on the priorities of this clinical approach in dementia care settings.

### **Strengths and Limitations**

The Q set was informed by drawing on multiple sources, and refined with rigour by crosschecking this with several independent peers. Whilst the majority of participants were satisfied with the breadth and depth of the Q set, a significant minority reported that several subjectively important aspects of team formulations were not available to them to sort, thus confining their final viewpoint.

Though helpful in being able to provide immediate assistance to participants during the research process, the presence of the researcher during Q sorts may have compelled some participants to portray a favourable view of team formulation (cf. Tourangeau & Yan, 2007). The positive phrasing of the condition of instruction may have also implied that formulation is inherently valued. These factors have the potential to limit the findings by prohibiting the expression of more critical views of formulation meetings, over which the existing literature has already been critiqued (see Chapter 1). However, direct and implicit negative views were actively promoted by requiring participants to sort all 56 items into the quasinormal distribution by making a series of relative judgments, thus prioritising some aspects at the expense of others.

The over-representation of psychologists within the sample may have prioritised certain viewpoints in this study. Additional factors may have emerged with greater numbers of carer participants. However, there were significant difficulties

recruiting residential and nursing staff to the study (for further discussion see Chapter 3).

### **Implications for Practice and Research**

The following implications are offered tentatively to avoid overgeneralising from the subjective viewpoints of participants in this study (Myers, 2000).

This study addressed a gap in the literature regarding facilitating clinicians' and non-qualified staffs' views. Exploring the similarities and differences between participants' viewpoints has highlighted the need for facilitators to remain reflective about their own perspective when formulating with teams; staff may have different priorities for the session that should be explored and negotiated.

Maintaining a curious and non-expert stance, developing the working alliance with staff teams, and exploring a holistic understanding of resident's needs were perceived to be the most important elements of successful formulation sessions by participants in this study. Effectively facilitating group formulation sessions requires a broad range of clinical skills (cf. James, 2011; Jackman et al., 2013; Jackman et al., 2015), many of which fall within the competence of clinical psychologists though not exclusively.

As a method of eliciting a range of perspectives and controlling for bias in research, Q methodology might also be applied in other settings to aid the evaluation of interventions from multiple perspectives.

Future research might helpfully explore the relationship between the identified factors and clinical outcomes from a team formulation approach in dementia care and other mental health settings. For example, whether the quality of the facilitator-team relationship influences satisfaction with sessions or staff wellbeing). Grounded theory might be used to develop a theoretical model of how formulation impacts on service user and staff outcomes (cf. Herhaus, 2014) to further inform effective and efficient clinical practice.

## **CONCLUSION**

This study explored multidisciplinary views about the use of team formulation sessions in dementia care using Q methodology. Psychologists and residential teams shared a number of perspectives regarding what they perceived as the most important content to explore during the formulation session. The role of group processes and working relationships was highlighted, in terms of providing a validating context for non-qualified staff to reflect on their clinical work with residents. Clinicians are encouraged to be reflective and flexible when negotiating the aims of formulating within residential services and developing working relationships with independent services.

## REFERENCES

- Ahmed, S. (2013). *An exploration of the views of interpreters & clinical psychologists about collaborative working in mental health: A Q methodological study* [unpublished doctoral thesis]. Staffordshire & Keele Universities, Staffordshire.
- Aston, R. (2009). A literature review exploring the efficacy of case formulations in clinical practice: What are the themes and pertinent issues? *The Cognitive Behaviour Therapist*, 2, 63-74. doi: 10.1017/S1754470X09000178.
- Berry, K., Barrowclough, C., & Wearden, A. (2009). A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behavioural & Cognitive Psychotherapy*, 37, 39-48. doi: 10.1017/S1352465808005018
- Berry, K., Haddock, G., Kellett, S., Roberts, C., Drake, R., & Barrowclough, C. (2015). Feasibility of a ward-based psychological intervention to improve staff & patient relationships in psychiatric rehabilitation settings. *British Journal of Clinical Psychology*. doi: 10.1111/bjc.12082
- British Psychological Society (2014). *Standards for doctoral programmes in clinical psychology*. Retrieved from [http://www.bps.org.uk/system/files/Public%20files/PaCT/dclinpsy\\_standards\\_approved\\_may\\_2014.pdf](http://www.bps.org.uk/system/files/Public%20files/PaCT/dclinpsy_standards_approved_may_2014.pdf)
- Callaby, P.L.M. (2007). Recognising the key predictors of caregiver burnout in dementia through facilitated mediation. *Generations Review*. Retrieved from <http://www.britishgerontology.org/DB/gr-editions-2/generations-review/recognising-the-key-predictors-of-caregiver-burnou.html>
- Christofides, S., Johnstone, L., & Musa, M. (2012). 'Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary team working. *Psychology & Psychotherapy: Theory, Research & Practice*, 85, 424-435. doi: 10.1111/j.2044-8341.2011.02041.x
- Cohen-Mansfield, J. (2000). Use of patient characteristics to determine nonpharmacologic interventions for behavioural and psychological symptoms of dementia. *International Psychogeriatrics*, 12 (1), 373-386. doi: 10.1017/S1041610200007304
- Collins, A. (2011). *Exploring psychological processes in reflective practice groups in acute inpatient wards: A grounded theory study* (Unpublished doctoral dissertation). Canterbury Christ Church University, Tunbridge Wells.
- Combes, H., Hardy, G., & Buchanan, L. (2008). Using Q methodology to involve people with intellectual disability in evaluating person-centred planning. *Journal of Applied Research in Intellectual Disabilities*, 17 (3), 149-159. doi: 10.1111/j.1468-3148.2004.00191.x

- Craven-Staines, S., Dexter-Smith, S., & Li, K. (2010). Integrating psychological formulations into older people's services – three years on (Part 3): Staff perceptions of formulation meetings. *PSIGE Newsletter*, 112, 16-22.
- Davenport, S. (2002). Acute wards: Problems & solutions. *Psychiatric Bulletin*, 26, 385-388. doi: 10.1192/pb.26.10.385
- Division of Clinical Psychology (2010). *The core purpose and philosophy of the profession*. Leicester: BPS.
- Division of Clinical Psychology (2011). *Good practice guidelines on the use of psychological formulation*. Leicester: BPS.
- Department of Health (2007). *Mental Health: New Ways of Working for Everyone*. London: DoH.
- Department of Health, Social Services & Public Safety (2015). *Care standards for nursing homes*. Retrieved from [http://www.rqia.org.uk/cms\\_resources/nursing\\_homes\\_standards\\_-\\_april\\_2015.pdf](http://www.rqia.org.uk/cms_resources/nursing_homes_standards_-_april_2015.pdf)
- Dexter-Smith, S. (2010). Integrating psychological formulations into older people's services: Three years on (Part 1). *PSIGE Newsletter*, 112, 8-11.
- Duffy, B., Oyebode, J. R., & Allen, J. (2009). Burnout among care staff for older adults with dementia: The role of reciprocity, self-efficacy and organizational factors. *Dementia*, 8 (4), 515-541. doi: 10.1177/1471301209350285
- Guttman, L. (1954). Some necessary conditions for common factor analysis. *Psychometrika*, 19, 149–161. doi: 10.1007/BF02289162
- Health Care Professions Council (2015). *Standards of proficiency: Practitioner psychologists*. London: HCPC. Retrieved from [http://www.hpc-uk.org/assets/documents/10002963sop\\_practitioner\\_psychologists.pdf](http://www.hpc-uk.org/assets/documents/10002963sop_practitioner_psychologists.pdf)
- Hood, N., Johnstone, L., & Christofides, S. (2013). The hidden solution? Staff experiences, views and understanding of the role of psychological formulation in multi-disciplinary teams. *Journal of Critical Psychology, Counselling & Psychotherapy*, 13 (2), 107-116.
- Jackman, L., Fielden, A., & Pearson, S. (2015). Micro-skills of group formulations in care settings: Working with expressions of staff distress. *Dementia*, 0 (0), 1-14. doi: 10.1177/1471301215596495
- Jackman, L. J., Wood-Mitchell, A., & James, I. A. (2013). Micro-skills of group formulations in care settings. *Dementia: The International Journal of Social Research and Practice*, 13 (1), 23–32. doi: 10.1177/1471301212442463
- James, I.A. (1999). Using a cognitive rationale to conceptualise anxiety in people with dementia. *Behavioural & Cognitive Psychotherapy*, 27 (4), 345-351.

- James, I.A. (2011). *Understanding challenging behaviour in dementia that challenges: A guide to assessment & treatment*. London: Jessica Kingsley.
- Johnstone, L. (2014). Using formulation in teams. In L. Johnstone & R. Dallos (Eds.) (2006). *Formulation in Psychology & Psychotherapy: Making Sense of People's Problems* (2<sup>nd</sup> ed.) (pp. 216-242). Oxford: Routledge.
- Johnstone, L. & Dallos, R. (Eds.) (2006). *Formulation in Psychology & Psychotherapy: Making Sense of People's Problems*. Oxford: Routledge.
- Kaiser, H.F. (1960). The application of electronic computers to factor analysis. *Educational & Psychological Measurement*, 20, 141–151. doi: 10.1177/001316446002000116
- Kaiser, H.F. (1970). A second generation Little Jiffy. *Psychometrika*, 35, 401–417. doi: 10.1007/BF02291817
- Kaufman, E.G., & Engel, S.A. (2014). Dementia & wellbeing: A conceptual framework based on Tom Kitwood's model of needs. *Dementia*, 0 (0), 1-15. doi: 10.1177/1471301214539690
- Kellett, S., Wilbram, M., Davis, C., & Hardy, G. (2014). Team consultancy using cognitive analytic therapy: A controlled study in assertive outreach. *Journal of Psychiatric & Mental Health Nursing*, 21, 687–697. doi: 10.1111/jpm.12123
- Kitwood, T., & Benson, S. (Eds.) (1995). *The new culture of dementia care*. London: Hawker.
- Lake, N. (2008). Developing skills in consultation 2: A team formulation approach. *Clinical Psychology Forum*, 186, 18-24
- Mackenzie, L., & James, I.A. (n.d.). *What works in challenging behaviour? What care staff think is most helpful*. Retrieved from <http://careinfo.org/images/conferences/james%20and%20mackenzie.pdf>
- Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs: Prentice-Hall.
- Mitchell, G., & Hastings, R.P. (2001). Coping, burnout, & emotion in staff working in community services for people with challenging behaviors. *American Journal on Mental Retardation*, 106 (5), 448-459.
- Murphy, S. A., Osborne, H., & Smith, I. (2013). Psychological consultation in older adult inpatient settings: A qualitative investigation of the impact on staff's daily practice and the mechanisms of change. *Aging & Mental Health*, 17 (4), 441-448. doi: 10.1080/13607863.2013.765829



- Myers, M. (2000). Qualitative research and the generalisability question: Standing firm with proteus. *The Qualitative Research Report*, 4 (3-4). Retrieved from <http://www.nova.edu/ssss/QR/QR4-3/myers.html>
- National Institute for Health and Care Excellence (2006). Dementia: Supporting people with dementia and their carers in health and social care (CG42). Retrieved from <https://www.nice.org.uk/guidance/cg42>
- Nowell, Z.C., Thornton, A., & Simpson, J. (2011). The subjective experience of personhood in dementia care settings. *Dementia*, 12 (4), 394-409. doi: 10.1177/1471301211430648
- Nursing & Midwifery Council (2015). *Standards for competence for registered nurses*. Retrieved from <https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-nurses.pdf>
- O'Connor, D., Phinney, A., Smith, A., Small, J., Perry, J., Drance, E., ...Beattie, L. (2007). Personhood in dementia care: Developing a research agenda for broadening the vision. *Dementia*, 6 (1), 121-142. doi: 10.1177/1471301207075648
- Onyett, S. (2007). *New ways of working for applied psychologists in health and social care: Working psychologically in teams*. Leicester: BPS.
- Rainforth, M. & Laurenson, M. (2014). A literature review of case formulation to inform mental health practice. *Journal of Psychiatric and Mental Health Nursing*, 21, 206–213. doi: 10.1111/jpm.12069
- Robson, J., & Quayle, G. (2009). Increasing the utility of psychological formulation: A case example from an acute mental health ward. *Clinical Psychology Forum*, 204, 25-29.
- Schmolck, P. (2014). PQMethod (Version 2.35) [Software]. Available from <http://schmolck.userweb.mwn.de/qmethod/downpqwin.htm>
- Schwandt, T.A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, & social constructionism. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research* (2<sup>nd</sup> ed.; pp. 189-214). Thousand Oaks: SAGE.
- Seel, E.L. (2008). *“What does it mean to me?”: A Q methodological exploration of the beliefs held about Asperger’s Syndrome/high functioning autism when the diagnosis is received in adulthood* [unpublished doctoral thesis]. University of Edinburgh, Scotland.
- Shinebourne, P. (2009). Using Q method in qualitative research. *International Journal of Qualitative Methods*, 8 (1). Retrieved from <https://ejournals.library.ualberta.ca/index.php/IJQM/article/view/980>

- Shirley, L. (2010). Sharing formulation with care staff using the Newcastle Model: Group problem solving. *PSIGE Newsletter*, 112, 55-61.
- Smebye, K.L., & Kirkevold, M. (2013). The influence of relationships on personhood in dementia care: A qualitative, hermeneutic study. *BMC Nursing*, 12 (29). Retrieved from <http://bmcnurs.biomedcentral.com/articles/10.1186/1472-6955-12-29>
- Smith, N.W. (2001). *Current systems in psychology: History, theory, research & applications*. Belmont: Wadsworth.
- Stainton Rogers, R. (1995). Q methodology. In J.A. Smith, R. Harre, & L. Van Langenhove (Eds.), *Rethinking Methods in Psychology* (pp. 178-192). London: SAGE.
- Summers, A. (2006). Psychological formulations in psychiatric care: Staff views on their impact. *Psychiatric Bulletin*, 30, 341-343. doi: 10.1192/pb.30.9.341
- Tajfel, H. (2010). *Social identity & intergroup relations*. Cambridge: University Press.
- Testad., I., Corbett, A., Aarsland, D., Lexow., K.O., Fossey, J., Woods, B., & Ballard, C. (2014). The value of personalized psychosocial interventions to address behavioral & psychological symptoms in people with dementia living in care home settings: A systematic review. *International Psychogeriatrics*, 26 (7), 1083-1098. doi: 10.1017/S1041610214000131
- Tourangeau, R., & Yan, T. (2007). Sensitive questions in surveys. *Psychological Bulletin*, 133 (5), 859-883. doi: 10.1037/0033-2909.133.5.859
- van Excel, J., & de Graaf, G. (2005). Q methodology: A sneak preview. Retrieved from <http://qmethod.org/articles/vanExcel.pdf>
- Wainwright, N., & Bergin, L. (2010). Introducing psychological formulations in acute older people's inpatient mental health ward: A service evaluation of staff views. *PSIGE Newsletter*, 112, 38-45.
- Watts, S., & Stenner, P. (2005). Doing Q methodology: Theory, method & interpretation. *Qualitative Research in Psychology*, 2 (1), 67-91. doi: 10.1191/1478088705qp022oa
- Watts, S., & Stenner, P. (2012). *Doing Q methodological research: Theory, method & interpretation*. London: SAGE.
- Williams, E. (2013). *Fifty shades greyer - Sexuality in older age: A Q methodological study exploring the beliefs held by care home managers, clinical psychologists & the general public towards older adult sexuality* [Unpublished doctoral thesis]. Staffordshire & Keele Universities, Staffordshire.

- Wood-Mitchell, A., Mackenzie, L., Stephenson, M., & James, I.A. (2007). Treating challenging behaviour in care settings: Audit of a community service using the neuropsychiatric inventory. *PSIGE Newsletter*, 101, 19-23.
- World Health Organisation (1992). The ICD-10 classification of mental & behavioural disorders: Diagnostic criteria for research. Retrieved from <http://www.who.int/classifications/icd/en/GRNBOOK.pdf>

## APPENDICES

### Appendix F Participant Information Sheet (Focus Groups)

#### Staffordshire & Keele Universities Doctorate in Clinical Psychology DClinPsy

*Faculty of Health Sciences, Staffordshire University.*

*Leek Road, Stoke-on-Trent ST4 2DF*


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Keele University

South Staffordshire and Shropshire Healthcare   
NHS Foundation Trust  
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#### FOCUS GROUP PARTICIPANT INFORMATION SHEET

**Project Title: Psychological formulation in residential teams working with people with dementia: An exploration of multidisciplinary views using Q-Methodology.**

Researcher: Jordan King

Thank you for taking the time to read this information sheet. We would like to invite you to take part in a research study. Before you decide we would like you to understand why the research is being done and what participating would involve. Please feel free to ask any questions that you may have about the study.

#### **What is the study about?**

This study is interested in finding out what views people have about psychological formulation meetings in teams. Formulation meetings often take place in residential care and nursing homes for people with dementia, and involve working with a clinician (e.g. psychologist) to develop an understanding of different issues and ideas for intervention.

#### **Why have I been invited to take part?**

You have been chosen to take part in the project for one of three reasons. You may be a member of staff working in a residential/nursing home for people with dementia; a residential/nursing home manager; or a clinical psychologist (qualified or in training). You will have experience of working with older adults with dementia and have attended a formulation meeting.

#### **Do I have to take part?**

No. Whether or not you take part in the study is entirely your choice. If you decide to take part, you have the right to withdraw from the discussion at any time although anything you have said up until that point will be included in the research. You do not have to give a reason if you decide to withdraw. Deciding not to take part in this project will not affect the service you receive from the psychology team.

#### **What will I be asked to do?**

If you decide to take part in the project, the researcher will meet with you and any other interested members of your team. You will be asked to talk about your views on the formulation meetings you have been part of. I am particularly interested in finding out which aspects of the session(s) you valued most or found useful, and which aspects were less important to you. You can choose how much or little you say. It is estimated that the focus group will last between 30-60 minutes, and will be held at your workplace at a convenient time.

The discussion will be audio recorded and will involve the researcher making notes. Afterwards the researcher will type the audio recording out to help draw out key statements about staff members' views on psychology formulation meetings. This will help develop a range of statements that will be used in another part of the research. Taking part in the discussion does not mean you have to participate in follow-up research, as this is voluntary.

(Version 2.0 - 10/12/15)

**Are there any benefits to taking part?**

We cannot promise any direct benefits from taking part in the study. However, we hope that the responses that you and other participants give will help to understand how different groups view the use of formulation in teams. This may help develop more effective and efficient ways of working together.

**Are there any risks or disadvantages to taking part?**

The risks of taking part in the focus group discussion are minimal. At the end there will be a debriefing to allow you to discuss anything that may have caused you concern. You are also welcome to contact me to discuss your experience and to answer any questions that you may have about the study.

**Will my participation in the study be anonymous?**

Yes. The content of the discussion will be anonymised. Direct quotes or statements may be used in a later part of the research, but will not feature your name or workplace. Written statements will be stored securely on a password-protected computer. All data will be stored securely for 5 years after completion of the project and destroyed thereafter, in accordance with Staffordshire University's Research Protocol.

The study will follow ethical and legal guidelines and all information will be kept confidential. Your name or workplace will not be recorded or reported in the study, so you should be able to speak freely during the focus group. As this research is being completed as part of an academic course the supervisors of the project (Dr Amanda Prime, Dr Helen Combes, & Dr Helen Scott) may view anonymised transcripts of the focus group discussion.

The only time that information will not be kept confidential would be if you reported something that was a concern to your own or someone else's safety; this would be reported to the clinical supervisor of the project.

**What will happen to the results of the study?**

The results of the study will be submitted as a Doctoral Thesis to Staffordshire and Keele Universities, and to an academic journal for publication. You will not be identifiable in either of these reports. It is hoped that the findings will increase professionals' knowledge about working with teams in residential settings.

**What if I need further information?**

If you have any questions or concerns about this study, or complaints about the way you have been treated, please contact one of the research team:

**Jordan King (Principal Researcher)**  
E: k030781c@student.staffs.ac.uk  
T: 07986 084320

**Dr Amanda Prime (Clinical Supervisor)**  
E: Amanda.Prime@sssfh.nhs.uk  
T: 01543 431529

**Dr Helen Scott (Academic Supervisor)**  
E: H.Scott@staffs.ac.uk  
T: 01782 294021

**Thank you for taking the time to read this information sheet and for considering whether to take part in this study.**

**If you wish to take part in the study please contact me by email or telephone and I will contact you to arrange a suitable time to meet.**

Jordan King  
Trainee Clinical Psychologist - Staffordshire and Keele Universities Doctorate in Clinical Psychology  
T: 07986 084320 E: k030781c@student.staffs.ac.uk

(Version 2.0 - 10/12/15)

## Appendix G

### Consent Form (Focus Groups)

#### Staffordshire & Keele Universities Doctorate in Clinical Psychology DClinPsy

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W <http://www.staffs.ac.uk>



Keele University

South Staffordshire and Shropshire Healthcare NHS  
NHS Foundation Trust  
A Keele University Teaching Trust

#### **FOCUS GROUP PARTICIPANT CONSENT FORM**

**Project Title:** Psychological formulation in residential teams working with people with dementia: An exploration of multidisciplinary views using Q-Methodology.

**Name of Researcher:** Jordan King, Trainee Clinical Psychologist  
(T: 07986 084320 E: k030781c@student.staffs.ac.uk)

**Thank you for agreeing to take part in this focus group. The purpose of this form is to make sure you are happy to take part in the research and that you know what it involves.**

Please tick if in  
agreement

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. I am aware that if I chose to withdraw then my data up until this point will still be used. ☐
3. I understand that my details will be kept confidential, and will be stored in accordance with the Data Protection Act 1988 and Staffordshire University research policies. ☐
4. I understand that only the researcher (Jordan King) and supervisors (Dr Amanda Prime, Dr Helen Scott, Dr Helen Combes) will have access to the anonymised data for analysis purposes. ☐

(Version 2.0 - 10/12/15)

Please tick if in  
agreement

5. I agree for my anonymised responses and interviews to be used in the write-up and any publication of this research.

☐

6. I agree to take part in the above focus group.

☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

## Appendix H

### Ethical Approval and Indemnity



Faculty of Health Sciences

#### ETHICAL APPROVAL FEEDBACK

<b>Researcher name:</b>	Jordan King
<b>Title of Study:</b>	Psychological formulation in residential teams working with people with dementia: an exploration of multidisciplinary views using Q-methodology
<b>Award Pathway:</b>	Doctorate in Clinical Psychology
<b>Status of approval:</b>	Approved

#### Action now needed:

Your project proposal has been approved by the Faculty's Ethics Panel and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

#### Comments for your consideration:

Thank you for revising and resubmitting your ethics form. You have addressed all the reviewers' comments in full.

We are happy to approve your proposal and wish you well with your research.

A handwritten signature in black ink, appearing to read 'Karen Rodham'.

**Signed:** Professor Karen Rodham  
Chair of the Faculty of Health Sciences Ethics Panel

**Date:** 1<sup>st</sup> July 2015



**Faculty of Health Sciences**

**ETHICAL APPROVAL FEEDBACK**

<b>Researcher name:</b>	Jordan King
<b>Title of Study:</b>	Psychological formulation in residential teams working with people with dementia.
<b>Award Pathway:</b>	Prof Doc Clin Psych
<b>Status of approval:</b>	Amendment approved

Thank you for your correspondence requesting approval of a minor amendment to your information sheet and consent form for the proposed focus groups.

Your amended application is approved. We wish you will with your research.

**Action now needed:**

Your amendment has now been approved by the Faculty's Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site



**Signed:** Prof Karen Rodham  
Chair of the Faculty of Health Sciences Ethics Panel

**Date:** 10<sup>th</sup> December 2015

Date: 21<sup>st</sup> August 2015

**To whom it may concern**


**Researcher:** Jordan King

**Study Title:** Psychological formulation in residential teams working with people with dementia: an exploration of multidisciplinary views using Q-methodology

I can confirm that this proposed project has gone through our due process for ethical approval here at Staffordshire University. The researcher is a registered student within our School of Psychology, Sport and Exercise and the project has the full support of the Faculty.

I can also confirm that the University has generic indemnity/insurance arrangements in place as stated on the attachment to this letter, that arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed, that arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the start of any data collection.



 Professor Nachiappan Chockalingam  
Chair,  
University Academic Ethics Sub-Committee

**Certificate of Employers' Liability Insurance(a)**

(Where required by regulation 5 of the Employers' Liability (Compulsory Insurance) Regulations 2008 (the Regulations), a copy of this certificate must be displayed at all places where you employ persons covered by the policy or an electronic copy of the certificate must be retained and be reasonably accessible to each employee to whom it relates).

Policy No. NHE-02CA03-0013

1. Name of policyholder Staffordshire University

2. Date of commencement of insurance policy 01 August 2015

3. Date of expiry of insurance policy 31 July 2016

We hereby certify that subject to paragraph 2:

1. The policy to which this certificate relates satisfies the requirements of the relevant law applicable in Great Britain, Northern Ireland, the Isle of Man, the Island of Jersey, the Island of Guernsey and the Island of Alderney (b)
2. (a) the minimum amount of cover provided by this policy is no less than £5 million (c)

Signed on behalf of Zurich Insurance plc (Authorised Insurer).

Signature



Stephen Lewis

Chief Executive Officer, Zurich Insurance plc (UK Branch)

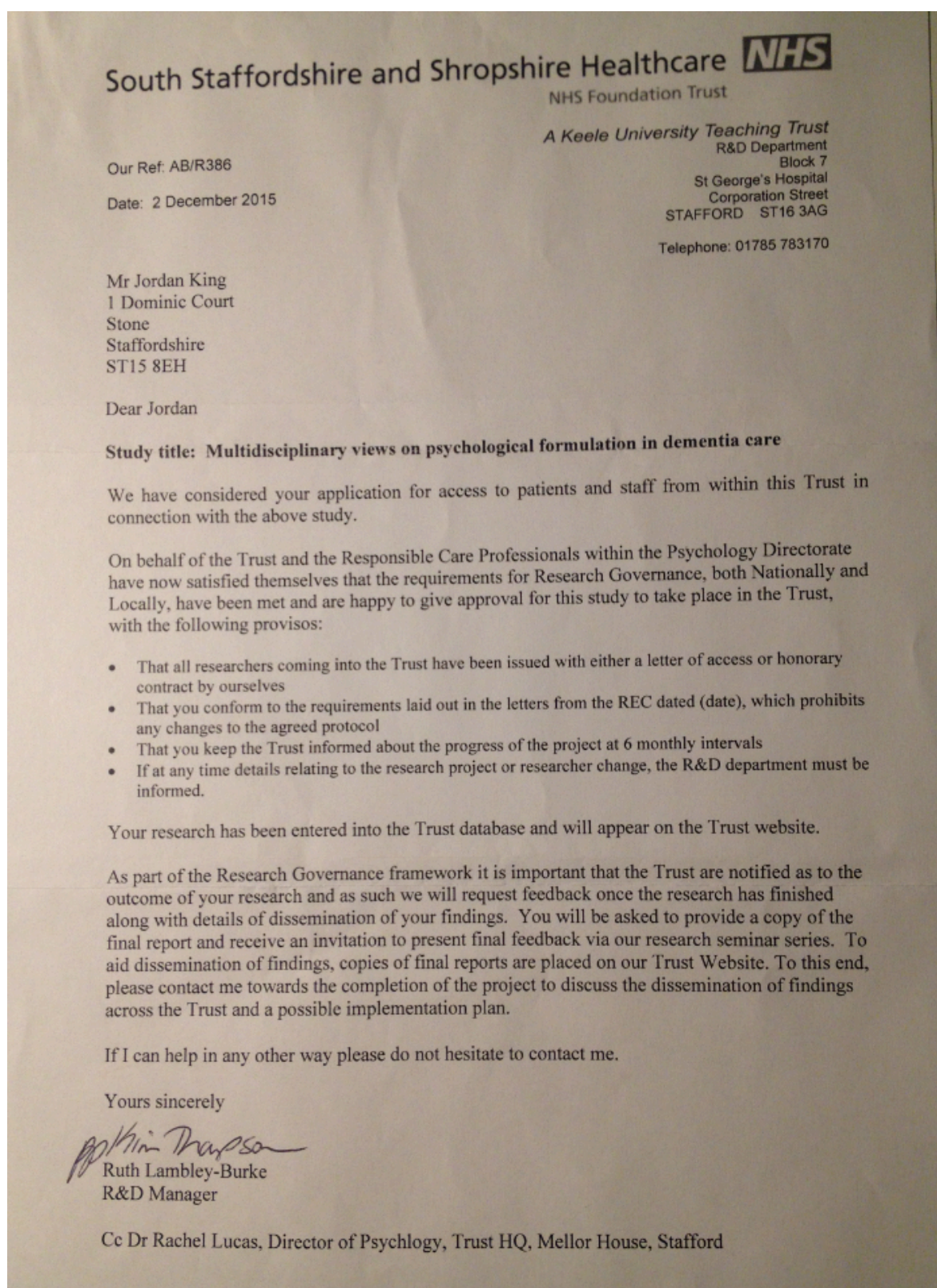
Zurich Municipal is a trading name of Zurich Insurance plc  
A public limited company  
Incorporated in Ireland  
Registration No. 13460 registered  
Office Zurich House, Ballsbridge Park, Dublin 4 Ireland.  
UK branch registered in England and Wales Registration No. BR 7983  
UK Branch Head Office  
The Zurich Centre, 3000 Parkway, Whiteley, Fareham, Hampshire PO15 7JZ

**Notes**

- (a) Where the employer is a company to which regulation 3(2) of the Regulations applies, the certificate shall state in a prominent place, either that the policy covers the holding company and all its subsidiaries, or that the policy covers the holding company and all its subsidiaries except any specifically excluded by name, or that the policy covers the holding company and only the named subsidiaries.
- (b) Specify applicable law as provided for in regulation 4(6) of the Regulations.
- (c) See regulation 3(1) of the Regulations and delete whichever of paragraphs 2(a) or 2(b) does not apply. Where 2(b) is applicable, specify the amount of cover provided by the relevant policy.

Authorised by the Central Bank of Ireland and subject to limited regulation by the Financial Conduct Authority. Details about the extent of our regulation by the Financial Conduct Authority are available from us on request

**Appendix I**  
NHS Research & Development Approval



## Appendix J

### Participant Information Sheet (Q sort)

#### Staffordshire & Keele Universities Doctorate in Clinical Psychology DClinPsy

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W <http://www.staffs.ac.uk>



South Staffordshire and Shropshire Healthcare   
NHS Foundation Trust  
A Keele University Teaching Trust

#### PARTICIPANT INFORMATION SHEET

**Project Title: Psychological formulation in residential teams working with people with dementia: An exploration of multidisciplinary views using Q-Methodology.**

Researcher: Jordan King

We would like to invite you to take part in a research study. Before you decide we would like you to understand why the research is being done and what participating would involve. Please feel free to ask any questions that you may have about the study.

#### **What is the study about?**

This study is interested in finding out what views people have about psychological formulation meetings in teams. Formulation meetings often take place in residential care and nursing homes for people with dementia, to develop an understanding of different issues and ideas for intervention.

#### **Why have I been invited to take part?**

You have been chosen to complete the project for one of three reasons. You may be a member of staff working in a residential/nursing home for people with dementia; a residential/nursing home manager; or a clinical psychologist (qualified or in training) who has experience of working with older adults with dementia. This study aims to recruit around 20 people who have experience of participating in a formulation meeting(s).

#### **Do I have to take part?**

No. Whether or not you take part in the study is entirely your choice. Once you have read this information you will be asked to fill in and sign a consent form if you agree to take part. You can choose to withdraw from the study at any time up until data analysis. If you have already taken part your results will be removed and destroyed. You do not have to give a reason if you decide to withdraw.

#### **What will I be asked to do?**

The researcher will meet you at your workplace or other venue at a convenient time. Each participant will be asked to 'sort' a number of readily pre-prepared statements relating to the use of formulation in residential/nursing teams working with people with dementia, depending on your viewpoint. You will be asked to rank the statements from strongly agree to strongly disagree. After completing this sorting task, you will be asked a number of questions to find out why you ordered the statements in the way you have. Participation should take between 30-45 minutes.

#### **Are there any benefits to taking part?**

We cannot promise any direct benefits from taking part in the study. However, we hope that the responses that you and other participants give will help to understand how different groups view the use of formulation in teams and that this may help develop more effective and efficient ways of working together.

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**Are there any risks or disadvantages to taking part?**

The risks of taking part in this study should be minimal. However, there is a slight possibility that you may experience some distress during the study or afterwards, when you reflect on the questions you answered. In both cases, I will provide you with a contact number of a support service who you can speak to about how you are feeling. You are also welcome to contact me to discuss your experience and to answer any questions that you may have.

**Will my participation in the study be anonymous?**

Yes. The study will follow ethical and legal guidelines and all information will be kept confidential. Your name or workplace will not be recorded or reported in the study, so you should be able to speak freely during the study. The only time that information will not be kept confidential would be if a participant reported something that was a concern to their own or someone else's safety; this would be reported to the clinical supervisor of the project.

Your responses during the study will be recorded on a grid alongside your personal identification number. These paper records will be kept in a locked briefcase before being transferred to a secure cabinet at Staffordshire University. Electronic data for analysis will be stored on a password-protected computer. All data will be stored securely for 5 years after completion of the research and destroyed thereafter, in accordance with Staffordshire University's Research Protocol.

**What will happen to the results of the study?**

The results of the study will be submitted as a Doctoral Thesis to Staffordshire and Keele Universities, and to an academic journal for publication. You will not be identifiable in either of these reports. It is hoped that the findings will increase professionals' knowledge about working with teams in residential settings.

**What if I need further information?**

If you have any questions or concerns about this study, or complaints about the way you have been treated, please contact one of the research team:

**Jordan King (Principal Researcher)**

E: k030781c@student.staffs.ac.uk  
T: 07986 084320

**Dr Amanda Prime (Clinical Supervisor)**

E: Amanda.Prime@sssf.nhs.uk  
T: 01543 431529

**Dr Helen Scott (Academic Supervisor)**

E: H.Scott@staffs.ac.uk  
T: 01782 294021

**Thank you for taking the time to read this information sheet and for considering whether to take part in this study.**

**If you wish to take part in the study please contact me by email or telephone and I will contact you to arrange a suitable time to meet.**

Jordan King  
Trainee Clinical Psychologist - Staffordshire and Keele Universities Doctorate in Clinical Psychology  
T: 07986 084320 E: k030781c@student.staffs.ac.uk

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## **Appendix K**

### **Email Invitation to Participants**

#### **Invitation letter to Independent Residential/Nursing Homes**

Dear Manager / Deputy Manager,

My name is Jordan King and I am currently completing my Doctoral training on the Clinical Psychology Training Programme at Staffordshire and Keele Universities.

I am writing to invite you to take part in a research project investigating staff member's views about psychological formulation sessions in residential/nursing care teams working with people with dementia. I am interested in meeting with home manager and members of staff who have participated in one of these sessions in the past 4 months, or has previous experience of these sessions.

I have included an information sheet providing further detail about the study. If after reading this you would like to take part in the study, and/or you are happy for me to ask your staff team to participate, please contact me by email or telephone and we can arrange a convenient time to meet. Completion of the study should take no longer than 40 minutes.

If you have any questions before making a decision about whether to participate please contact me.

Thank you for your time and consideration.

Kind regards,

Jordan King  
Trainee Clinical Psychologist  
Staffordshire and Keele Universities  
(E: k030781c@student.staffs.ac.uk T: 07986 084320)

## **Invitation letter/email to SSSFT Employees**

Dear Clinician,

My name is Jordan King and I am currently completing my Doctoral training on the Clinical Psychology Training Programme at Staffordshire and Keele Universities.

I am writing to invite you to take part in a research project investigating different views about psychological formulation sessions in residential/nursing care teams working with people with dementia.

To take part in the study you must be a clinician (e.g. CPN, Clinical Psychologist – qualified or in training) who has facilitated a formulation session with a staff team in the past 12 months.

I have included an information sheet providing further detail about the study. If after reading this you would like to take part in the study, please contact me by email or telephone and we can arrange a convenient time to meet.

Completion of the study should take no longer than 40 minutes. I have received approval from SSSFT Research and Development Office who have agreed that this study can take place during working hours.

If you have any questions before making a decision about whether to participate please contact me.

Thank you for your time and consideration.

Kind regards,

Jordan King  
Trainee Clinical Psychologist  
South Staffordshire and Shropshire Healthcare NHS Foundation Trust  
(E: [Jordan.King@sssft.nhs.uk](mailto:Jordan.King@sssft.nhs.uk) T: 07986 084320)



## Appendix L

### Participant Demographics

Q sort Number	Participant Demographics				
	Gender	Age	Profession TP - Trainee Psychologist QP - Qualified Psychologist CA - Health Care Assistant NU - Nurse OT - Trainee Occupational Therapist	Number of team formulation sessions attended	Nature of involvement FA - Facilitating the session PA - Participating in the session
1	M	35	TP	2	FA
2	F	26	TP	6	FA
3	F	27	TP	2	FA
4	F	28	TP	2	FA
5	F	31	TP	2	FA
6	F	28	TP	1	FA
7	F	41	QP	20+	FA
8	M	41	CA	1	PA
9	F	54	NU	2	PA
10	F	51	CA	3	PA
11	F	29	CA	4	PA
12	F	59	NU	1	PA
13	F	37	QP	20+	FA
14	F	44	NU	5	PA
15	F	34	QP	20+	FA
16	F	45	QP	20+	FA
17	F	22	OT	2	PA

## Appendix M

### Consent Form (Q sort)

#### Staffordshire & Keele Universities Doctorate in Clinical Psychology DClinPsy

*Faculty of Health Sciences, Staffordshire University.*

*Leek Road, Stoke-on-Trent ST4 2DF*

E [DClinPsy@staffs.ac.uk](mailto:DClinPsy@staffs.ac.uk)

T 01782 294007

W <http://www.staffs.ac.uk>



Keele University

South Staffordshire and Shropshire Healthcare   
NHS Foundation Trust  
A Keele University Teaching Trust

#### RESEARCH PARTICIPANT CONSENT FORM

**Project Title:** Psychological formulation in residential teams working with people with dementia: An exploration of multidisciplinary views using Q-Methodology.

**Name of Researcher:** Jordan King, Trainee Clinical Psychologist  
(T: 07986 084320 E: k030781c@student.staffs.ac.uk)

**Thank you for agreeing to take part in this study. The purpose of this form is to make sure you are happy to take part in the research and that you know what it involves.**

Please tick if in  
agreement

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. I am aware of how to withdraw my data from the study up until data analysis. ☐
3. I understand that my details will be kept confidential, and will be stored in accordance with the Data Protection Act 1988 and Staffordshire University research policies. ☐
4. I understand that only the researcher (Jordan King) and supervisors (Dr Amanda Prime, Dr Helen Scott, Dr Helen Combes) will have access to the anonymised data for analysis purposes. ☐

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Please tick if in  
agreement

5. I agree to be interviewed discussing my specific responses, and understand  
that these interviews may be recorded.

☐

6. I agree for my anonymised responses and interviews to be used in the write-up and any  
publication of this research.

☐

7. I agree to take part in the above study.

☐

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Name of Participant

---

Date

---

Signature

---

Name of Person  
taking consent

---

Date

---

Signature

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## Appendix N

### Pre-sorting Questionnaire

#### PRE-SORTING INFORMATION SHEET

Participant  
Number:

001

1. What is your age?

\_\_\_\_\_ years

2. What is your gender?

- ☐ Male  
☐ Female  
☐ Transgender  
☐ Prefer not to say

3. What is your ethnic group/background?

\_\_\_\_\_ ☐ Prefer not to say

4. Please indicate which group of people most closely relates to you:

- ☐ Health Care Assistant  
☐ Support Worker  
☐ Nurse  
☐ Care Home Manager  
☐ Clinical Psychologist (in training)  
☐ Clinical Psychologist (qualified)  
☐ Other residential staff (please state) \_\_\_\_\_  
☐ Other clinical staff (please state) \_\_\_\_\_

5. What has most of your experience of formulation sessions been?

- ☐ Participating in formulation sessions as a member of a team  
☐ Facilitating formulation sessions with teams  
☐ Supporting the recommendations from formulation sessions

6. How many formulation sessions have you been involved in?

\_\_\_\_\_

7. How long ago was the last time you were involved in a formulation session?

\_\_\_\_\_

8. In a few words, what do you think is the main reason for using formulation sessions in teams working in residential/nursing homes?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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## Appendix O

### Q set

No.	Statement Wording
1	During the meeting, the team should reach a clearer understanding of the resident's cognitive abilities or the extent of their neurological impairment.
2	The meeting should involve identifying which behaviours the team find most distressing.
3	The team should be encouraged to brainstorm ideas about why the behaviour that challenges is occurring.
4	The team should plan how to help the resident have more choice/control about how they spend their time.
5	The team needs to know that the home manager supports the meetings and their ideas.
6	The team should generate ideas about what the resident might be thinking when they are distressed.
7	The facilitator should acknowledge that they don't necessarily have all the answers, but that the meeting is about working on the problem together.
8	The intervention plan decided in the meeting should be fed-back to the resident and their family, as appropriate.
9	During the meeting, the facilitator should give ideas to the team about how to change things for the resident.
10	The team should develop ideas about why particular situations lead to the resident behaving in a manner that challenges.
11	At the meeting, the team can share information with one another that they have not had an opportunity to do elsewhere.
12	The team thinks together about ways of being with residents that other team members have found helpful.
13	The meeting should be hopeful that the resident's problems can begin to be addressed in the current placement.
14	The facilitator should help the group to move on from difficult situations by discussing what can be done about it.
15	The facilitator should acknowledge when issues relating to the wider organisation come up or suggest how these will be raised elsewhere.
16	The meeting should be for residential/nursing staff only, managers and relatives should not attend.
17	Staff members should be given time away from their normal duties to attend the meeting.
18	The discussion should highlight positive qualities or characteristics about the resident.

- 19 The meeting should help the team to recognise the impact of important events from the resident's life story.
- 20 The session should help the group to understand the likely effects of the person's medication.
- 21 The meeting should help the team to understand the resident's behaviour as a way of communicating an unmet need.
- 22 The facilitator should reinforce the good work that the staff team is already doing (e.g. praising efforts to date).
- 23 During the meeting the team should be guided through activities to help understand the resident's experience (e.g. 'Imaging waking up in a room you don't recognise...').
- 24 As many staff as possible should attend the meeting, regardless of their level of training or experience.
- 25 The facilitator should use examples from his/her own experience to help introduce the team to new ideas.
- 26 During the meeting the facilitator and team should work together to develop strategies for intervention.
- 27 You should make sure that those staff who work closest with the resident have their views and concerns heard during the meeting.
- 28 The team's existing ideas should be developed and improved during the meeting, rather than trying something completely new.
- 29 The facilitator should get to know the resident before the meeting takes place.
- 30 The meeting should provide the team with an experience of being listened to and taken seriously by another professional.
- 31 The meeting should acknowledge the emotional impact of working with the resident.
- 32 The meeting's facilitator should be someone outside of the care organisation (e.g. NHS clinician).
- 33 There should be a clear description of exactly what happens during an episode of behaviour that challenges.
- 34 If relevant, situations that pose an immediate risk should be discussed with a view to developing a management plan.
- 35 There should be some continuing contact between the staff team and facilitator after the meeting has ended.
- 36 There should be a good relationship between the facilitating clinician and the staff team in order for the meeting to be useful.
- 37 The meeting should consider the contribution of any past mental health problems to the resident's current difficulties.
- 38 The people involved in the meeting should consider how to improve the care-home environment to benefit the resident's wellbeing.

- 39 The meeting should take place in a private room.
  - 40 The facilitator's role is to provide an expert opinion on the situation.
  - 41 The meeting should be non-judgmental, so that the team is able to speak openly about their concerns and challenges.
  - 42 The meeting should ensure that strategies are the least-restrictive option for managing a situation.
  - 43 Everyone in the group should have input rather than the discussion being dominated by one member of staff.
  - 44 The meeting should be repeated with different groups of team members (e.g. across shifts).
  - 45 Unhelpful views about the resident should be challenged during meetings.
  - 46 Tasks should be delegated at the end of the meeting.
  - 47 The facilitator should be responsible for ensuring the strategies are doable for the team.
  - 48 The team's existing skills and expertise in caring for the resident should be recognised during the meeting.
  - 49 People at the meeting should use what is known about the resident to help meet his/her individual needs.
  - 50 The facilitator should ask the group for feedback about whether the discussion is helpful.
  - 51 The team should come up with ideas about how the resident might be feeling based on their appearance.
  - 52 Background information about the resident should be obtained before the meeting.
  - 53 A psychologist should facilitate the formulation meeting.
  - 54 After the meeting, the team should be provided with a written summary of the points discussed and agreed strategies.
  - 55 The team should think about the impact of the resident's declining physical health or age-related illness.
  - 56 The facilitator should verbally summarise the discussion to draw the group's attention to key information.
-

## Appendix P

### Forced Choice Distribution Matrix and Condition of Instruction

[illegible]



## Appendix Q

### Post-sort Interview Schedule

#### POST-SORT INTERVIEW SCHEDULE

Participant  
Number:

**001**

1. How did you find the experience of completing the Q-sort?
2. What made you place the cards in the +5 positions?
3. What made you place the cards in the -5 positions?
4. Did you feel that there was anything missing from the statement set – e.g. a view that you had about formulation sessions that was not included?
5. Is there anything else that you would like to add about the experience?

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## Appendix R

### Debrief Sheet

#### DEBRIEF SHEET

Thank you for taking part in this research project.

We hope that you have enjoyed taking part in the study. It is hoped that your views, in addition to others', will be used to help develop the use of formulation in residential/nursing teams working with people with dementia.

If you have any questions or concerns about this study, or complaints about the way you have been treated, please contact one of the research team:

Jordan King (Principal Researcher)  
E: k030781c@student.staffs.ac.uk  
T: 07986 084320

Dr Amanda Prime (Clinical Supervisor)  
E: Amanda.Prime@sssf.nhs.uk  
T: 01543 431529

If you feel distressed or upset by the research, and would like to speak to someone who is not involved with the study for any reason, the following contacts may be useful:

Samaritans  
**08457 909090**

Staffordshire Mental Health Helpline  
**0808 800 2234**

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#### OPTION TO WITHDRAW YOUR DATA:

If you have changed your mind and would like your responses to be removed from the research, please contact the researcher (T: 07986 084320; E: k030781c@student.staffs.ac.uk) quoting your participant number:

[e.g.] **001**

(Version 1.0 - 02/07/15)

## Appendix S

### Correlation Matrix Between Sorts

SORTS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1 01TP02FA	100	9	33	34	33	28	27	25	21	-16	10	23	42	32	21	13	25
2 02TP06FA		100	28	42	44	51	45	14	38	-4	-11	31	36	26	26	36	38
3 03TP02FA			100	51	35	50	44	14	19	-5	18	36	51	44	46	40	33
4 04TP02FA				100	42	63	35	46	28	2	7	36	50	39	41	54	35
5 05TP02FA					100	57	39	39	36	7	15	29	39	40	35	27	28
6 06TP01FA						100	43	27	35	20	-2	32	37	55	40	61	39
7 07QP20FA							100	10	39	7	24	34	35	40	33	52	25
8 08CA01PA								100	0	-7	-1	6	26	0	32	23	8
9 20NU02PA									100	19	17	33	41	48	38	40	32
10 09CA03PA										100	21	7	-28	20	2	10	6
11 10CA04PA											100	23	8	11	7	4	21
12 11NU01PA												100	26	19	0	7	19
13 12QP20FA													100	38	38	35	25
14 18NU05PA														100	43	40	32
15 13QP20FA															100	43	12
16 14QP20FA																100	24
17 15OT02PA																	100

## Appendix T

Factor Arrays (Q-sort values for each statement)

No.	Statement	Factor Arrays		
		F1	F2	F3
1	During the meeting, the team should reach a clearer understanding of the resident's cognitive abilities or the extent of their neurological impairment.	1	4	-4
2	The meeting should involve identifying which behaviours the team find most distressing.	1	-2	1
3	The team should be encouraged to brainstorm ideas about why the behaviour that challenges is occurring.	4	1	3
4	The team should plan how to help the resident have more choice/control about how they spend their time.	-1	1	-2
5	The team needs to know that the home manager supports the meetings and their ideas.	2	-2	-2
6	The team should generate ideas about what the resident might be thinking when they are distressed.	3	1	-1
7	The facilitator should acknowledge that they don't necessarily have all the answers, but that the meeting is about working on the problem together.	3	-4	3
8	The intervention plan decided in the meeting should be fed-back to the resident and their family, as appropriate.	-2	1	0
9	During the meeting, the facilitator should give ideas to the team about how to change things for the resident.	-5	-1	0
10	The team should develop ideas about why particular situations lead to the resident behaving in a manner that challenges.	2	4	4
11	At the meeting, the team can share information with one another that they have not had an opportunity to do elsewhere.	0	3	-3
12	The team thinks together about ways of being with residents that other team members have found helpful.	0	0	-2
13	The meeting should be hopeful that the resident's problems can begin to be addressed in the current	1	-3	3

	placement.			
14	The facilitator should help the group to move on from difficult situations by discussing what can be done about it.	-3	-	5
15	The facilitator should acknowledge when issues relating to the wider organisation come up or suggest how these will be raised elsewhere.	-2	-1	0
16	The meeting should be for residential/nursing staff only, managers and relatives should not attend.	-4	-2	-5
17	Staff members should be given time away from their normal duties to attend the meeting.	2	4	4
18	The discussion should highlight positive qualities or characteristics about the resident.	2	2	1
19	The meeting should help the team to recognise the impact of important events from the resident's life story.	4	3	0
20	The session should help the group to understand the likely effects of the person's medication.	-1	-1	0
21	The meeting should help the team to understand the resident's behaviour as a way of communicating an unmet need.	5	1	0
22	The facilitator should reinforce the good work that the staff team is already doing (e.g. praising efforts to date).	3	0	-3
23	During the meeting the team should be guided through activities to help understand the resident's experience (e.g. 'Imaging waking up in a room you don't recognise...').	0	-2	-1
24	As many staff as possible should attend the meeting, regardless of their level of training or experience.	1	-4	1
25	The facilitator should use examples from his/her own experience to help introduce the team to new ideas.	-3	-1	-3
26	During the meeting the facilitator and team should work together to develop strategies for intervention.	3	-2	1
27	You should make sure that those staff who work closest with the resident have their views and concerns heard during the meeting.	1	-3	3
28	The team's existing ideas should be developed and improved during the meeting, rather than trying something completely new.	-3	-1	-2
29	The facilitator should get to know the resident	-2	0	0

	before the meeting takes place.			
30	The meeting should provide the team with an experience of being listened to and taken seriously by another professional.	1	3	2
31	The meeting should acknowledge the emotional impact of working with the resident.	1	0	-2
32	The meeting's facilitator should be someone outside of the care organisation (e.g. NHS clinician).	-4	-2	2
33	There should be a clear description of exactly what happens during an episode of behaviour that challenges.	2	1	1
34	If relevant, situations that pose an immediate risk should be discussed with a view to developing a management plan.	-2	5	5
35	There should be some continuing contact between the staff team and facilitator after the meeting has ended.	0	-1	0
36	There should be a good relationship between the facilitating clinician and the staff team in order for the meeting to be useful.	-2	-4	4
37	The meeting should consider the contribution of any past mental health problems to the resident's current difficulties.	-1	1	-1
38	The people involved in the meeting should consider how to improve the care-home environment to benefit the resident's wellbeing.	0	2	-4
39	The meeting should take place in a private room.	0	-3	3
40	The facilitator's role is to provide an expert opinion on the situation.	-5	-5	-4
41	The meeting should be non-judgmental, so that the team is able to speak openly about their concerns and challenges.	4	0	2
42	The meeting should ensure that strategies are the least-restrictive option for managing a situation.	-1	5	2
43	Everyone in the group should have input rather than the discussion being dominated by one member of staff.	2	-1	4
44	The meeting should be repeated with different groups of team members (e.g. across shifts).	-3	-5	-2
45	Unhelpful views about the resident should be challenged during meetings.	-3	3	-3

46	Tasks should be delegated at the end of the meeting.	-2	2	-5
47	The facilitator should be responsible for ensuring the strategies are doable for the team.	-4	-3	-1
48	The team's existing skills and expertise in caring for the resident should be recognised during the meeting.	4	2	2
49	People at the meeting should use what is known about the resident to help meet his/her individual needs.	3	0	1
50	The facilitator should ask the group for feedback about whether the discussion is helpful.	0	-3	-3
51	The team should come up with ideas about how the resident might be feeling based on their appearance.	-1	2	-4
52	Background information about the resident should be obtained before the meeting.	5	0	-1
53	A psychologist should facilitate the formulation meeting.	-4	-4	-1
54	After the meeting, the team should be provided with a written summary of the points discussed and agreed strategies.	0	0	2
55	The team should think about the impact of the resident's declining physical health or age-related illness.	-1	4	-1
56	Everyone in the group should have input rather than the discussion being dominated by one member of staff.	-1	2	1

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## Appendix U

### Factor Exemplifying Q sort for F1: *Working together to identify residents' unmet needs*

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
During the meeting, the facilitator should give ideas to the team about how to change things for the resident	The meeting should be for residential/nursing staff only, managers and relatives should not attend.	The team's existing ideas should be developed and improved during the meeting, rather than trying something completely new.	There should be a good relationship between the facilitating clinician and the staff team in order for the meeting to be useful.	The meeting should ensure that strategies are the least-restrictive option for managing a situation.	The meeting should take place in a private room.	During the meeting, the team should reach a clearer understanding of the resident's cognitive abilities or the extent of their neurological impairment.	The discussion should highlight positive qualities or characteristics about the resident.	The facilitator should acknowledge that they don't necessarily have all the answers, but that the meeting is about working on the problem together.	The meeting should be non-judgmental, so that the team is able to speak openly about their concerns and challenges.	The meeting should help the team to understand the resident's behaviour as a way of communicating an unmet need.
The facilitator's role is to provide an expert opinion on the situation.	The meeting's facilitator should be someone outside of the care organisation (e.g. NHS clinician).	The meeting should be repeated with different groups of team members (e.g. across shifts).	If relevant, situations that pose an immediate risk should be discussed with a view to developing a management plan.	The team should think about the impact of the resident's declining physical health or age-related illness.	There should be some continuing contact between the staff team and facilitator after the meeting has ended.	The meeting should provide the team with an experience of being listened to and taken seriously by another professional.	The team should develop ideas about why particular situations lead to the resident behaving in a manner that challenges.	During the meeting the facilitator and team should work together to develop strategies for intervention.	The meeting should help the team to recognise the impact of important events from the resident's life story.	Background information about the resident should be obtained before the meeting.
	The facilitator should be responsible for ensuring the strategies are doable for the team.	The facilitator should help the group to move on from difficult situations by discussing what can be done about it.	The facilitator should get to know the resident before the meeting takes place.	The meeting should consider the contribution of any past mental health problems to the resident's current difficulties.	The team thinks together about ways of being with residents that other team members have found helpful.	The meeting should involve identifying which behaviours the team find most distressing.	There should be a clear description of exactly what happens during an episode of behaviour that challenges.	The team should generate ideas about what the resident might be thinking when they are distressed.	The team should be encouraged to brainstorm ideas about why the behaviour that challenges is occurring.	
	A psychologist should facilitate the formulation meeting.	The facilitator should use examples from his/her own experience to help introduce the team to new ideas.	Tasks should be delegated at the end of the meeting.	The team should come up with ideas about how the resident might be feeling based on their appearance.	The people involved in the meeting should consider how to improve the care-home environment to benefit the resident's wellbeing.	As many staff as possible should attend the meeting, regardless of their level of training or experience.	Everyone in the group should have input rather than the discussion being dominated by one member of staff.	The facilitator should reinforce the good work that the staff team is already doing (e.g. praising efforts to date).	The team's existing skills and expertise in caring for the resident should be recognised during the meeting.	
		Unhelpful views about the resident should be challenged during meetings.	The intervention plan decided in the meeting should be fed-back to the resident and their family, as appropriate.	The session should help the group to understand the likely effects of the person's medication.	During the meeting the team should be guided through activities to help understand the resident's experience (e.g. 'Imaging waking up in a room you don't recognise...').	The meeting should be hopeful that the resident's problems can begin to be addressed in the current placement.	The team needs to know that the home manager supports the meetings and their ideas.	People at the meeting should use what is known about the resident to help meet his/her individual needs.		
			The facilitator should acknowledge when issues relating to the wider organisation come up or suggest how these will be raised elsewhere.	The facilitator should verbally summarise the discussion to draw the group's attention to key information.	The facilitator should ask the group for feedback about whether the discussion is helpful.	The meeting should acknowledge the emotional impact of working with the resident.	Staff members should be given time away from their normal duties to attend the meeting.			
				The team should plan how to help the resident have more choice/control about how they spend their time.	After the meeting, the team should be provided with a written summary of the points discussed and agreed strategies.	You should make sure that those staff who work closest with the resident have their views and concerns heard during the meeting.				
					At the meeting, the team can share information with one another that they have not had an opportunity to do elsewhere.					



## Factor Exemplifying Q sort for F2 (Positive Pole): *Prioritising the needs of the resident through active care planning*

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
The meeting should be repeated with different groups of team members (e.g. across shifts).	A psychologist should facilitate the formulation meeting.	The facilitator should be responsible for ensuring the strategies are doable for the team.	The meeting should be for residential/nursing staff only, managers and relatives should not attend.	There should be some continuing contact between the staff team and facilitator after the meeting has ended.	The meeting should acknowledge the emotional impact of working with the resident.	The team should generate ideas about what the resident might be thinking when they are distressed.	The discussion should highlight positive qualities or characteristics about the resident.	At the meeting, the team can share information with one another that they have not had an opportunity to do elsewhere.	Staff members should be given time away from their normal duties to attend the meeting.	If relevant, situations that pose an immediate risk should be discussed with a view to developing a management plan.
The facilitator's role is to provide an expert opinion on the situation.	The facilitator should acknowledge that they don't necessarily have all the answers, but that the meeting is about working on the problem together.	The meeting should take place in a private room.	During the meeting the team should be guided through activities to help understand the resident's experience (e.g. 'Imaging waking up in a room you don't recognise...').	Everyone in the group should have input rather than the discussion being dominated by one member of staff.	People at the meeting should use what is known about the resident to help meet his/her individual needs.	The meeting should help the team to understand the resident's behaviour as a way of communicating an unmet need.	The facilitator should verbally summarise the discussion to draw the group's attention to key information.	The meeting should help the team to recognise the impact of important events from the resident's life story.	During the meeting, the team should reach a clearer understanding of the resident's cognitive abilities or the extent of their neurological impairment.	The meeting should ensure that strategies are the least-restrictive option for managing a situation.
As many staff as possible should attend the meeting, regardless of their level of training or experience.	There should be a good relationship between the facilitating clinician and the staff team in order for the meeting to be useful.	The meeting should be hopeful that the resident's problems can begin to be addressed in the current placement.	During the meeting the facilitator and team should work together to develop strategies for intervention.	The facilitator should acknowledge when issues relating to the wider organisation come up or suggest how these will be raised elsewhere.	Background information about the resident should be obtained before the meeting.	The intervention plan decided in the meeting should be fed-back to the resident and their family, as appropriate.	The team should come up with ideas about how the resident might be feeling based on their appearance.	The facilitator should help the group to move on from difficult situations by discussing what can be done about it.	The team should develop ideas about why particular situations lead to the resident behaving in a manner that challenges.	
		The facilitator should ask the group for feedback about whether the discussion is helpful.	The meeting should involve identifying which behaviours the team find most distressing.	The session should help the group to understand the likely effects of the person's medication.	The facilitator should reinforce the good work that the staff team is already doing (e.g. praising efforts to date).	The meeting should consider the contribution of any past mental health problems to the resident's current difficulties.	The team's existing skills and expertise in caring for the resident should be recognised during the meeting.	Unhelpful views about the resident should be challenged during meetings.	The team should think about the impact of the resident's declining physical health or age-related illness.	
		You should make sure that those staff who work closest with the resident have their views and concerns heard during the meeting.	The meeting's facilitator should be someone outside of the care organisation (e.g. NHS clinician).	The facilitator should use examples from his/her own experience to help introduce the team to new ideas.	The team thinks together about ways of being with residents that other team members have found helpful.	The team should be encouraged to brainstorm ideas about why the behaviour that challenges is occurring.	Tasks should be delegated at the end of the meeting.	The meeting should provide the team with an experience of being listened to and taken seriously by another professional.		
			The team needs to know that the home manager supports the meetings and their ideas.	The team's existing ideas should be developed and improved during the meeting, rather than trying something completely new.	The facilitator should get to know the resident before the meeting takes place.	There should be a clear description of exactly what happens during an episode of behaviour that challenges.	The people involved in the meeting should consider how to improve the care-home environment to benefit the resident's wellbeing.			
				During the meeting, the facilitator should give ideas to the team about how to change things for the resident.	After the meeting, the team should be provided with a written summary of the points discussed and agreed strategies.	The team should plan how to help the resident have more choice/control about how they spend their time.				
					The meeting should be non-judgmental, so that the team is able to speak openly about their concerns and challenges.					

## Factor Exemplifying Q sort for F2 (Negative Pole): *Prioritising the needs of the team by concentrating on group processes*

+5	+4	+3	+2	+1	0	-1	-2	-3	-4	-5
The meeting should be repeated with different groups of team members (e.g. across shifts).	A psychologist should facilitate the formulation meeting.	The facilitator should be responsible for ensuring the strategies are doable for the team.	The meeting should be for residential/nursing staff only, managers and relatives should not attend.	There should be some continuing contact between the staff team and facilitator after the meeting has ended.	The meeting should acknowledge the emotional impact of working with the resident.	The team should generate ideas about what the resident might be thinking when they are distressed.	The discussion should highlight positive qualities or characteristics about the resident.	At the meeting, the team can share information with one another that they have not had an opportunity to do elsewhere.	Staff members should be given time away from their normal duties to attend the meeting.	If relevant, situations that pose an immediate risk should be discussed with a view to developing a management plan.
The facilitator's role is to provide an expert opinion on the situation.	The facilitator should acknowledge that they don't necessarily have all the answers, but that the meeting is about working on the problem together.	The meeting should take place in a private room.	During the meeting the team should be guided through activities to help understand the resident's experience (e.g. 'Imaging waking up in a room you don't recognise...').	Everyone in the group should have input rather than the discussion being dominated by one member of staff.	People at the meeting should use what is known about the resident to help meet his/her individual needs.	The meeting should help the team to understand the resident's behaviour as a way of communicating an unmet need.	The facilitator should verbally summarise the discussion to draw the group's attention to key information.	The meeting should help the team to recognise the impact of important events from the resident's life story.	During the meeting, the team should reach a clearer understanding of the resident's cognitive abilities or the extent of their neurological impairment.	The meeting should ensure that strategies are the least-restrictive option for managing a situation.
As many staff as possible should attend the meeting, regardless of their level of training or experience.	There should be a good relationship between the facilitating clinician and the staff team in order for the meeting to be useful.	The meeting should be hopeful that the resident's problems can begin to be addressed in the current placement.	During the meeting the facilitator and team should work together to develop strategies for intervention.	The facilitator should acknowledge when issues relating to the wider organisation come up or suggest how these will be raised elsewhere.	Background information about the resident should be obtained before the meeting.	The intervention plan decided in the meeting should be fed-back to the resident and their family, as appropriate.	The team should come up with ideas about how the resident might be feeling based on their appearance.	The facilitator should help the group to move on from difficult situations by discussing what can be done about it.	The team should develop ideas about why particular situations lead to the resident behaving in a manner that challenges.	
		The facilitator should ask the group for feedback about whether the discussion is helpful.	The meeting should involve identifying which behaviours the team find most distressing.	The session should help the group to understand the likely effects of the person's medication.	The facilitator should reinforce the good work that the staff team is already doing (e.g. praising efforts to date).	The meeting should consider the contribution of any past mental health problems to the resident's current difficulties.	The team's existing skills and expertise in caring for the resident should be recognised during the meeting.	Unhelpful views about the resident should be challenged during meetings.	The team should think about the impact of the resident's declining physical health or age-related illness.	
	You should make sure that those staff who work closest with the resident have their views and concerns heard during the meeting.	The meeting's facilitator should be someone outside of the care organisation (e.g. NHS clinician).	The facilitator should use examples from his/her own experience to help introduce the team to new ideas.	The team thinks together about ways of being with residents that other team members have found helpful.	The team should be encouraged to brainstorm ideas about why the behaviour that challenges is occurring.	Tasks should be delegated at the end of the meeting.	The meeting should provide the team with an experience of being listened to and taken seriously by another professional.			
		The team needs to know that the home manager supports the meetings and their ideas.	The team's existing ideas should be developed and improved during the meeting, rather than trying something completely new.	The facilitator should get to know the resident before the meeting takes place.	There should be a clear description of exactly what happens during an episode of behaviour that challenges.	The people involved in the meeting should consider how to improve the care-home environment to benefit the resident's wellbeing.				
			During the meeting, the facilitator should give ideas to the team about how to change things for the resident.	After the meeting, the team should be provided with a written summary of the points discussed and agreed strategies.	The team should plan how to help the resident have more choice/control about how they spend their time.					
				The meeting should be non-judgmental, so that the team is able to speak openly about their concerns and challenges.						

### Factor Exemplifying Q sort for F3: *Being heard - Valuing the relationship between the facilitating clinician and the care team*

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
The meeting should be for residential/nursing staff only, managers and relatives should not attend.	The facilitator's role is to provide an expert opinion on the situation.	The facilitator should ask the group for feedback about whether the discussion is helpful.	The meeting should acknowledge the emotional impact of working with the resident.	A psychologist should facilitate the formulation meeting.	The facilitator should acknowledge when issues relating to the wider organisation come up or suggest how these will be raised elsewhere.	As many staff as possible should attend the meeting, regardless of their level of training or experience.	The meeting should ensure that strategies are the least-restrictive option for managing a situation.	The meeting should take place in a private room.	Everyone in the group should have input rather than the discussion being dominated by one member of staff.	The facilitator should help the group to move on from difficult situations by discussing what can be done about it.
Tasks should be delegated at the end of the meeting.	During the meeting, the team should reach a clearer understanding of the resident's cognitive abilities or the extent of their neurological impairment.	The facilitator should reinforce the good work that the staff team is already doing (e.g. praising efforts to date).	The team needs to know that the home manager supports the meetings and their ideas.	The team should generate ideas about what the resident might be thinking when they are distressed.	The facilitator should get to know the resident before the meeting takes place.	There should be a clear description of exactly what happens during an episode of behaviour that challenges.	The meeting should be non-judgmental, so that the team is able to speak openly about their concerns and challenges.	You should make sure that those staff who work closest with the resident have their views and concerns heard during the meeting.	Staff members should be given time away from their normal duties to attend the meeting.	If relevant, situations that pose an immediate risk should be discussed with a view to developing a management plan.
	The team should come up with ideas about how the resident might be feeling based on their appearance.	The facilitator should use examples from his/her own experience to help introduce the team to new ideas.	The team thinks together about ways of being with residents that other team members have found helpful.	The team should think about the impact of the resident's declining physical health or age-related illness.	The session should help the group to understand the likely effects of the person's medication.	During the meeting the facilitator and team should work together to develop strategies for intervention.	The team's existing skills and expertise in caring for the resident should be recognised during the meeting.	The meeting should be hopeful that the resident's problems can begin to be addressed in the current placement.	The team should develop ideas about why particular situations lead to the resident behaving in a manner that challenges.	
	The people involved in the meeting should consider how to improve the care-home environment to benefit the resident's wellbeing.	At the meeting, the team can share information with one another that they have not had an opportunity to do elsewhere.	The team should plan how to help the resident have more choice/control about how they spend their time.	Background information about the resident should be obtained before the meeting.	There should be some continuing contact between the staff team and facilitator after the meeting has ended.	The discussion should highlight positive qualities or characteristics about the resident.	The meeting should provide the team with an experience of being listened to and taken seriously by another professional.	The facilitator should acknowledge that they don't necessarily have all the answers, but that the meeting is about working on the problem together.	There should be a good relationship between the facilitating clinician and the staff team in order for the meeting to be useful.	
		Unhelpful views about the resident should be challenged during meetings.	The meeting should be repeated with different groups of team members (e.g. across shifts).	The facilitator should be responsible for ensuring the strategies are doable for the team.	The intervention plan decided in the meeting should be fed-back to the resident and their family, as appropriate.	The meeting should involve identifying which behaviours the team find most distressing.	The meeting's facilitator should be someone outside of the care organisation (e.g. NHS clinician).	The team should be encouraged to brainstorm ideas about why the behaviour that challenges is occurring.		
			The team's existing ideas should be developed and improved during the meeting, rather than trying something completely new.	During the meeting the team should be guided through activities to help understand the resident's experience (e.g. 'Imaging waking up in a room you don't recognise...').	The meeting should help the team to understand the resident's behaviour as a way of communicating an unmet need.	People at the meeting should use what is known about the resident to help meet his/her individual needs.	After the meeting, the team should be provided with a written summary of the points discussed and agreed strategies.			
				The meeting should consider the contribution of any past mental health problems to the resident's current difficulties.	The meeting should help the team to recognise the impact of important events from the resident's life story.	The facilitator should verbally summarise the discussion to draw the group's attention to key information.				
					During the meeting, the facilitator should give ideas to the team about how to change things for the resident.					

## Appendix V

### Crib Sheets to Inform Factor Interpretations

#### Notes:

*Characterising statements (i.e. +5, +4, -4, -5) removed from higher/lower item lists.*

\* *Item identified as a distinguishing statement for that factor at  $p < .05$*

\*\* *Item identified as a distinguishing statement for that factor at  $p < .01$*

~~text~~ *Item identified as a consensus statement at  $p > .05$*

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### FACTOR 1

#### **Items Ranked at +5**

- 21.\*\* The meeting should help the team to understand the resident's behaviour as a way of communicating an unmet need.
- 52.\*\* Background information about the resident should be obtained before the meeting.

#### **Items Ranked at +4**

- 41. The meeting should be non-judgmental, so that the team is able to speak openly about their concerns and challenges.
- 19. The meeting should help the team to recognise the impact of important events from the resident's life story.
- 3. The team should be encouraged to brainstorm ideas about why the behaviour that challenges is occurring.
- ~~48. The team's existing skills and expertise in caring for the resident should be recognised during the meeting.~~

#### **Items Ranked Higher in Factor 1 Array than in Other Factor Arrays**

- 5.\*\* The team needs to know that the home manager supports the meetings and their ideas (+2).
- 6. The team should generate ideas about what the resident might be thinking when they are distressed (+3).
- 22.\*\* The facilitator should reinforce the good work that the staff team is already doing (e.g. praising efforts to date) (+3).
- 23. During the meeting the team should be guided through activities to help understand the resident's experience (e.g. 'Imaging waking up in a room you don't recognise...') (0).
- 26.\* During the meeting the facilitator and team should work together to develop strategies for intervention (+3).

- 31. The meeting should acknowledge the emotional impact of working with the resident (+1).
- 33.\*\* There should be a clear description of exactly what happens during an episode of behaviour that challenges (+2).
- 49. People at the meeting should use what is known about the resident to help meet his/her individual needs (+3).
- 50.\*\* The facilitator should ask the group for feedback about whether the discussion is helpful (0).

### **Items Ranked Lower in Factor 1 Array than in Other Factor Arrays**

- 8.\* The intervention plan decided in the meeting should be fed-back to the resident and their family, as appropriate (-2).
- ~~10. The team should develop ideas about why particular situations lead to the resident behaving in a manner that challenges (+2).~~
- 14.\*\* The facilitator should help the group to move on from difficult situations by discussing what can be done about it (-3).
- 15.\* The facilitator should acknowledge when issues relating to the wider organisation come up or suggest how these will be raised elsewhere (-2).
- 17.\* Staff members should be given time away from their normal duties to attend the meeting (+2).
- 28. The team's existing ideas should be developed and improved during the meeting, rather than trying something completely new (-3).
- 29.\* The facilitator should get to know the resident before the meeting takes place (-2).
- ~~30. The meeting should provide the team with an experience of being listened to and taken seriously by another professional (+1).~~
- 34.\*\* If relevant, situations that pose an immediate risk should be discussed with a view to developing a management plan (-2).
- 42.\*\* The meeting should ensure that strategies are the least-restrictive option for managing a situation (-1).
- 56.\*\* The facilitator should verbally summarise the discussion to draw the group's attention to key information (-1).

### **Items Ranked at -4**

- 32.\* The meeting's facilitator should be someone outside of the care organisation (e.g. NHS clinician).
- 47. The facilitator should be responsible for ensuring the strategies are doable for the team.
- 53. A psychologist should facilitate the formulation meeting.
- 16. The meeting should be for residential/nursing staff only, managers and relatives should not attend.

### **Items Ranked at -5**

- 9.\*\* During the meeting, the facilitator should give ideas to the team about how to change things for the resident.
  - 40. The facilitator's role is to provide an expert opinion on the situation.
- 

## **FACTOR 2**

### **Items Ranked at +5**

- 34. If relevant, situations that pose an immediate risk should be discussed with a view to developing a management plan.
- 42.\*\* The meeting should ensure that strategies are the least-restrictive option for managing a situation.

### **Items Ranked at +4**

- 17. Staff members should be given time away from their normal duties to attend the meeting.
- 1.\* During the meeting, the team should reach a clearer understanding of the resident's cognitive abilities or the extent of their neurological impairment.
- ~~10. The team should develop ideas about why particular situations lead to the resident behaving in a manner that challenges.~~
- 55.\*\* The team should think about the impact of the resident's declining physical health or age-related illness.

### **Items Ranked Higher in Factor 2 Array than in Other Factor Arrays**

- 4.\*\* The team should plan how to help the resident have more choice/control about how they spend their time (+1).
- 8. The intervention plan decided in the meeting should be fed-back to the resident and their family, as appropriate (+1).
- 11.\*\* At the meeting, the team can share information with one another that they have not had an opportunity to do elsewhere (+3).
- 16.\*\* The meeting should be for residential/nursing staff only, managers and relatives should not attend (-2).
- 25. The facilitator should use examples from his/her own experience to help introduce the team to new ideas (-1).
- 28. The team's existing ideas should be developed and improved during the meeting, rather than trying something completely new (-1).
- ~~30. The meeting should provide the team with an experience of being listened to and taken seriously by another professional (+3).~~

- 37.\* The meeting should consider the contribution of any past mental health problems to the resident's current difficulties (+1).
- 38. The people involved in the meeting should consider how to improve the care-home environment to benefit the resident's wellbeing (+2).
- 45.\*\* Unhelpful views about the resident should be challenged during meetings (+3).
- 46.\*\* Tasks should be delegated at the end of the meeting (+2).
- 51.\*\* The team should come up with ideas about how the resident might be feeling based on their appearance (+2).
- 56. The facilitator should verbally summarise the discussion to draw the group's attention to key information (+2).

### **Items Ranked Lower in Factor 2 Array than in Other Factor Arrays**

- 2.\*\* The meeting should involve identifying which behaviours the team find most distressing (-2).
- 3. The team should be encouraged to brainstorm ideas about why the behaviour that challenges is occurring (+1).
- 13.\*\* The meeting should be hopeful that the resident's problems can begin to be addressed in the current placement (-3).
- 23. During the meeting the team should be guided through activities to help understand the resident's experience (e.g. 'Imaging waking up in a room you don't recognise...') (-2).
- 26.\*\* During the meeting the facilitator and team should work together to develop strategies for intervention (-2).
- 27.\*\* You should make sure that those staff who work closest with the resident have their views and concerns heard during the meeting (-3).
- ~~35. There should be some continuing contact between the staff team and facilitator after the meeting has ended (-1).~~
- 39.\*\* The meeting should take place in a private room (-3).
- 41.\* The meeting should be non-judgmental, so that the team is able to speak openly about their concerns and challenges (0).
- 43.\*\* Everyone in the group should have input rather than the discussion being dominated by one member of staff (-1).
- 49. People at the meeting should use what is known about the resident to help meet his/her individual needs (0).

### **Items Ranked at -4**

- 53. A psychologist should facilitate the formulation meeting.
- 7.\*\* The facilitator should acknowledge that they don't necessarily have all the answers, but that the meeting is about working on the problem together.

- 36.\*\* There should be a good relationship between the facilitating clinician and the staff team in order for the meeting to be useful.
- 24.\*\* As many staff as possible should attend the meeting, regardless of their level of training or experience.

#### **Items Ranked at -5**

- 44.\*\* The meeting should be repeated with different groups of team members (e.g. across shifts).
- 40. The facilitator's role is to provide an expert opinion on the situation.

### **FACTOR 3**

#### **Items Ranked at +5**

- 14.\* The facilitator should help the group to move on from difficult situations by discussing what can be done about it.
- 34. If relevant, situations that pose an immediate risk should be discussed with a view to developing a management plan.

#### **Items Ranked at +4**

- 43.\* Everyone in the group should have input rather than the discussion being dominated by one member of staff.
- 17. Staff members should be given time away from their normal duties to attend the meeting.
- ~~10. The team should develop ideas about why particular situations lead to the resident behaving in a manner that challenges.~~
- 36.\*\* There should be a good relationship between the facilitating clinician and the staff team in order for the meeting to be useful.

#### **Items Ranked Higher in Factor 3 Array than in Other Factor Arrays**

- 9. During the meeting, the facilitator should give ideas to the team about how to change things for the resident (0).
- 13.\* The meeting should be hopeful that the resident's problems can begin to be addressed in the current placement (+3).
- 15. The facilitator should acknowledge when issues relating to the wider organisation come up or suggest how these will be raised elsewhere (0).
- ~~20. The session should help the group to understand the likely effects of the person's medication (0).~~
- 27.\* You should make sure that those staff who work closest with the resident have their views and concerns heard during the meeting (+3).



- 32.\*\* The meeting's facilitator should be someone outside of the care organisation (e.g. NHS clinician) (+2).
- 39.\*\* The meeting should take place in a private room (+3).
- 44. The meeting should be repeated with different groups of team members (e.g. across shifts) (-2).
- 47. The facilitator should be responsible for ensuring the strategies are doable for the team (-1).
- 53.\*\* A psychologist should facilitate the formulation meeting (-1).
- 54. After the meeting, the team should be provided with a written summary of the points discussed and agreed strategies (+2).

### **Items Ranked Lower in Factor 3 Array than in Other Factor Arrays**

- 4. The team should plan how to help the resident have more choice/control about how they spend their time (-2).
- 6.\* The team should generate ideas about what the resident might be thinking when they are distressed (-1).
- 11.\*\* At the meeting, the team can share information with one another that they have not had an opportunity to do elsewhere (-3).
- 12. The team thinks together about ways of being with residents that other team members have found helpful (-2).
- ~~18. The discussion should highlight positive qualities or characteristics about the resident (+1).~~
- 19.\*\* The meeting should help the team to recognise the impact of important events from the resident's life story (0).
- 21. The meeting should help the team to understand the resident's behaviour as a way of communicating an unmet need (0).
- 22.\*\* The facilitator should reinforce the good work that the staff team is already doing (e.g. praising efforts to date) (-3).
- 31.\* The meeting should acknowledge the emotional impact of working with the resident (-2).
- 52. Background information about the resident should be obtained before the meeting (-1).

### **Items Ranked at -4**

- 40.\* The facilitator's role is to provide an expert opinion on the situation.
- 1.\*\* During the meeting, the team should reach a clearer understanding of the resident's cognitive abilities or the extent of their neurological impairment.
- 51.\*\* The team should come up with ideas about how the resident might be feeling based on their appearance.

- 38.\*\* The people involved in the meeting should consider how to improve the care-home environment to benefit the resident's wellbeing.

**Items Ranked at -5**

16. The meeting should be for residential/nursing staff only, managers and relatives should not attend.
- 46.\*\* Tasks should be delegated at the end of the meeting.

## **Chapter 3: Commentary and Reflective Review**

### **Personal and Professional Reflections on my Research Journey**

## **ABSTRACT**

This final chapter provides a review and commentary of the process of undertaking the research component of a clinical psychology training programme. Primarily the authors' reasons for selecting the topic of team formulation for his thesis are outlined. Subsequently the chapter is organised into three sections: (1) Reflections on undertaking a literature review of the outcomes associated with developing psychological formulations within mental health teams, (2) Reflective commentary on conducting a Q methodological study concerning the ways in which multidisciplinary staff value group formulations in dementia care settings, and (3) An account of the personal and professional learning that has occurred during the undertaking of this thesis. Hereafter it is written in the first person to provide a reflexive account of the author's subjective experiences.

Abstract word count: 126

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## INTRODUCTION

Reflective practice has been understood in a variety of ways (Carroll, 2009; Wilkinson, 1999), though is defined by Bolton (2010) as “an in-depth consideration of events or situations...[involving] reviewing or reliving the experience to bring it into focus, and replaying from diverse points of view” (p. 19). This forms a core aspect of professional and ethical conduct (British Psychological Society, 2009a; Roth & Pilling, 2007).

Schön (1983) encourages practitioners to reflect both *in-action* – making adjustments whilst practicing, and *on-action* – examining a situation in detail to reach new understandings. The purpose of this paper is to reflect on action – specifically the experience of undertaking a research thesis in partial fulfillment of the doctorate in clinical psychology, comprising a literature review of the impact of team formulation sessions in secondary mental health services (Chapter 1), and empirical research report exploring the multidisciplinary viewpoints regarding the use of group formulation in dementia care settings (Chapter 2).

Using several of Boyd and Fales’ (1983) non-linear components of reflective practice – namely by identifying and clarifying any concerns, and subsequently being open to a variety of perspectives taken from internal and external sources of information – I aim to critically appraise my methodology, analysis and findings. The chapter moves towards deciding how best to act on the outcome of this process (the sixth component outlined by Boyd & Fales, 1983).

### Selecting a Research Topic

My interest in the use of psychological formulation in teams stems from personal experience of having benefitted from this approach in my past capacity working in residential services for looked-after children. The developmental trauma that children had experienced was often re-enacted in their relationships with the staff team, including myself. At the time the service received consultation from a clinical psychologist, focussed on understanding the needs of the young people and how we as a staff group could meet these. I recall having been reinvigorated

by these meetings yet also frustrated by the lack of direct therapeutic involvement provided; discussing this further with my supervisor reframed my understanding of such sessions as aiming to support the systemic therapeutic work undertaken by the whole team (cf. Dent & Golding, 2008).

The first clinical training placement I undertook was also in the same sector; I gained experience of co-facilitating case consultation sessions with professional networks around children and young people in foster or adoptive care, and evaluated this aspect of the service (King, 2014). At this early stage in my training, I was perhaps preoccupied with acquiring theoretical and clinical knowledge that would help me to guide other professionals in their work using indirect psychological approaches. Respondents in my service evaluation valued both the content and process of consultation sessions facilitated by psychologists and therapists within the team. Whilst reportedly they appreciated the specialist knowledge used to develop contextual understandings of young people's emotional regulation, behavioural and interpersonal difficulties and how this was used to inform therapeutic care plans, they also reliably endorsed consultations for having provided timely emotional support to carers and professionals.

A subsequent placement with a community dementia team introduced me to the Newcastle Model (James, 2011), a clinical approach to formulating with residential teams caring for people with dementia whose behaviour challenges. This model places significant emphasis on collaboratively identifying the core unmet needs of the resident that are precipitating their behaviour and distress (Cohen-Mansfield, 2000), with view to facilitating the staff team to reconnect with the personhood of the resident and develop bespoke, non-pharmacological interventions to meet these. This seemed to be an accepted way of consulting with dementia care teams, yet when I completed some background research into this I was surprised to find few studies exploring its use. Furthermore, the views of facilitating clinicians and staff who contributed to formulation sessions were lacking. I concluded that exploring their viewpoints on formulation sessions, particularly what multidisciplinary teams valued most about this approach, might reveal important insights that could enrich the provision of this method of working.

## **PART 1: LITERATURE REVIEW**

A literature review was undertaken to obtain a grounding in the different outcomes and experiences associated with formulating in teams prior to embarking on my empirical research project. I sought to apply a systematic process to ensure that I was selecting the most pertinent papers and did not overlook important insights. Scoping searches revealed that the peer-reviewed literature was somewhat sparse, thus I made the decision to include grey literature and published service evaluations to provide an overview of the current evidence that may be of use to other clinicians with an interest in this area of practice. In hindsight the variability of included studies may limit generalizations from their findings. However, the review also intends to provide a springboard for others to identify avenues for further investigation, thus developing the evidence base as it relates to team formulation.

With no prior experience of undertaking a full literature review, I significantly underestimated the time and effort that was required to identify, process and evaluate relevant papers. Whilst the papers included in my review shared certain characteristics to warrant valid comparisons being made between them, the mixed nature of their design and methodology created some difficulties in terms of appraising their relative quality. No suitable critical appraisal tools were identified, thus I developed my own tools to evaluate sources of bias across the studies, with items being drawn for standardised instruments (e.g. Critical Appraisal Skills Programme, 2013a, 2013b). Furthermore, the scoring system utilised facilitated a direct comparison of studies' methodological quality based on a crudely standardised quality score (Table 1.4).

## **PART 2: RESEARCH REPORT**

### **Design**

Given the limited number of studies into the views of multidisciplinary staff on team formulation, an exploratory qualitative method was sought. The intention to recruit heterogeneous occupational groups of participants limited the options further. Q methodology was selected for several reasons. The combination of quantitative and qualitative methods was likely to reveal participants' manifest and latent viewpoints on the topic, and indicate the extent to which these are shared perspectives. Q methodology is also compatible with my epistemological position, discussed in Chapter 2. The analysis process is less vulnerable to researcher bias than other interpretive techniques (Cordingley, Webb & Hillier, 1997). Meaningful results were likely to emerge even with small participant numbers (Watts & Stenner, 2012), and the Q sort procedure enables the collection of data in a relatively short period of time compared with semi-structured interviews as part of a grounded theory study, *per se*. These practical considerations were important given participants time was likely to be at a premium as the research was conducted during working hours.

### **Recruitment and Data Collection**

Having sent out the recruitment invitations, I was excited to receive several replies from psychologists. Initially these tended to be from peers currently in training at the same academic institution, and qualified clinicians working within the same older adult mental health specialty as I was placed at the time. Whilst a standard recruitment procedure was maintained, my personal and professional relationships within these contexts may have facilitated the recruitment of trainee and qualified psychologists to the study. Luff, Ferreira and Meyer (2011) note that in order to engage residential homes in the research process, the investigator must sensitively liaise with managerial 'gatekeeper' within the organisation. Unfortunately, I was unable to recruit from a nursing home that had expressed an informal interest in the study due to difficulties contacting the manager to confirm her approval for me to complete the research project with their staff. Efforts were made to contact other providers, and those that responded identified having done so due to having a good relationship with my clinical supervisor who had facilitated



formulation meetings with them previously. Whilst the relationships between the research team and participants may have limited the expression of a full range of views in other qualitative methodological designs, the Q methodological process helps minimise this bias (Watts & Stenner, 2012).

The nuances of Q methodology, namely the sorting of pre-prepared statements into a distribution grid, initially took some participants aback. With clarification and reassurance all participants engaged well, and several expressed having enjoyed the process more than a traditional semi-structured interview. As a novice researcher attempting to implement an unfamiliar mixed methodology, this was encouraging feedback to receive.

Staff caring for older adults with dementia in residential settings are at risk of burnout, manifested through feeling emotionally exhausted, low self-efficacy and distancing self from residents (Duffy, Oyebode & Allen, 2009). In the past residential services for people with dementia have been perceived as having low organisational and professional status, in which paradoxically the least qualified, poorly paid and overworked staff have the most direct contact with service users (Cantley, 2001). The residential and nursing staff who participated in the current study seemed enthusiastic and positively affected by being invited to contribute their opinion. At the time this caused me to reflect on the value of this research in facilitating the expression of marginalised voices in the literature. Several individuals requested a summary of findings, which I intend to provide following completion of this thesis.

## **Analysis and Findings**

Q methodology is yet to achieve status as a mainstream analytic approach (Watts & Stenner, 2012), and as such I had received minimal formal training in this approach. However, guidance from my academic supervisor, support from peers also undertaking research using Q method, and other online and print resources (e.g. past doctoral theses) were extremely helpful in advancing the analytic and interpretative process. In particular, it was helpful to have generated exemplar Q sort arrays for each of the factor viewpoints (Appendix U) and systematically identify the key distinguishing statements for each of these through integrating the

statistical output with the crib sheets (Appendix V). Although results were checked with a supervisor with significant experience of Q methodology, I did not verify the validity of my interpretations with participants identified as loading highly onto respective factors. This would have added further rigour and validity to the findings.

### **Ethical Issues**

The research project and procedure was approved by Staffordshire University's Research Ethics Committee and the local NHS trust's Research and Development department. However, I was required to justify the omission of seeking prior written approval from residential homes at the stage of submitting my proposal on the grounds that the study's inclusion criteria may render sites ineligible for participation by the time that the study was ready to commence. Potentially this could have resulted in staff feeling disappointed and disempowered, in addition to affecting sensitive relationships between community dementia services and residential care homes.

Whilst the comprehensive review procedures of these organisations seemed excessive at the time for a study that was not seeking to recruit vulnerable participants, in hindsight I recognise the importance of these safeguards in terms of ensuring research governance is upheld for the protection of participants and host institutions. To this effect I abided at all times by the British Psychological Society's (2009b) ethical guidelines for research, for example by ensuring participants were informed of how to withdraw their data from the study up until the point of analysis should they chose to do so retrospectively.

### **PART 3: PERSONAL AND PROFESSIONAL REFLEXIVITY**

In keeping with a thesis arguing for the usefulness of formulation, I will now consider the impact of undertaking this thesis on my personal and professional identity, and vice versa using psychological concepts drawn from Schema Therapy.

Schemas are cognitive and emotional patterns of relating to oneself and other people, which develop during childhood and are elaborated throughout the lifespan (Young, Klosko & Weishaar, 2003). Everyone has schemas and develops different ways of coping with these, such as by avoiding experiences that activate maladaptive schemas. Personally I am aware of having internalized high, often unrealistic standards for my own conduct and performance resulting in continually striving for perfection in my academic work.

Throughout the process of completing the current thesis, this 'Unrelenting Standards' schema acted as both a motivator by continually driving me to improve the quality of my research design and written report, and internal critic when I did not achieve the goals I set for myself. Given the competing demands of participating in teaching, clinical placements, and my empirical research, I became frustrated with being unable to dedicate my attention wholly to each aspect of clinical training. I oscillated between surrendering to my schema by working intensely for periods of time, and seeking short-term relief by avoiding the research process.

Increasingly I recognised that the latter of these coping modes was in conflict with my personal and professional values, which include developing my competence as a psychologist in order to provide effective help to those experiencing emotional distress. This dissonance fuelled the development of what I now perceive to be more healthy and productive working practices, which were essential to enabling me to complete this research process and will benefit my practice as a psychologist. For example, being more disciplined with how I organise my workload and resisting the urge to become passive in response to feeling overwhelmed at times.

Throughout my development a high value has been placed on academic achievement during childhood and professional competence in adulthood. In the early stages of my research thesis, I had difficulty reconciling the amount of time and effort that was necessary to progress the project at its various stages with my desire to be a proficient therapist. Reflecting on this process has highlighted its impact on developing my critical thinking skills through appraising a body of literature, appreciation of a variety of viewpoints through research using Q methodology, and my professional knowledge of formulation - arguably one of the defining characteristics of psychology.

## **CONCLUSION**

Taking a moment to explore an experience or event is often a natural and spontaneous process (Boyd & Fales, 1983). Reflecting on the research process through this chapter and my research journal has enabled me to explore my practice and development as a critical consumer of and contributor to the evidence base. The views of participants in my empirical research and the studies included in my literature review support the practice of psychological formulation in multidisciplinary teams, which reportedly enable staff to develop new insights into their work with services users. As yet, team formulation has little demonstrable direct benefits to service users themselves. Further investigation using rigorous methods of the costs and benefits of a team formulation approach relative to competing approaches (e.g. care programme approach, treatment as usual) would be prudent to overcome the gaps in the literature, and inform future models of multidisciplinary mental health service provision.

Having arrived at the end of this research journey, I am furnished with new insights, skills and confidence. In spite of the aforementioned challenges in completing this project and the anticipated demands of post-qualification clinical practice, I hope that my future career will afford me the opportunity to continue to contribute to the literature through undertaking and disseminating empirical research.

## REFERENCES

- Bolton, G. E. J. (2010). *Reflective practice: Writing and professional development* (3<sup>rd</sup> ed.). London: Sage.
- Boyd, E. M., & Fales, A. W. (1983). Reflective learning: Key to learning from experience. *Journal of Humanistic Psychology*, 23, 99-117.
- British Psychological Society (2009a). *Code of ethics and conduct*. Leicester: British Psychological Society. Retrieved from [http://www.bps.org.uk/system/files/documents/code\\_of\\_ethics\\_and\\_conduct.pdf](http://www.bps.org.uk/system/files/documents/code_of_ethics_and_conduct.pdf)
- British Psychological Society (2009b). *Code of human research ethics*. Leicester: British Psychological Society. Retrieved from [http://www.bps.org.uk/sites/default/files/documents/code\\_of\\_human\\_research\\_ethics.pdf](http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf)
- Cantley, C. (Ed.) (2001). *A handbook of dementia care*. Buckingham: Open University Press.
- Carroll, M. (2009). From mindfulness to mindful practice: On learning reflection in supervision. *Psychotherapy in Australia*, 15 (4), 40-51.
- Critical Appraisal Skills Programme (2013a). *CASP Randomised Controlled Trial Checklist*. Retrieved from [http://media.wix.com/ugd/dded87\\_40b9ff0bf53840478331915a8ed8b2fb.pdf](http://media.wix.com/ugd/dded87_40b9ff0bf53840478331915a8ed8b2fb.pdf)
- Critical Appraisal Skills Programme (2013b). *CASP Qualitative Checklist*. Retrieved from [http://media.wix.com/ugd/dded87\\_29c5b002d99342f788c6ac670e49f274.pdf](http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf)
- Cohen-Mansfield, J. (2000). Use of patient characteristics to determine nonpharmacologic interventions for behavioural and psychological symptoms of dementia. *International Psychogeriatrics*, 12 (1), 373-386. doi: 10.1017/S1041610200007304
- Cordingley, L., Webb, C., & Hillier, V. (1997). Q methodology. *Nurse Researcher*, 3 (3), 3-45.
- Dent, H. R., & Golding, K.S. (2008). Engaging the network: Consultation for looked after and adopted children. In K.S. Golding, H.R. Dent, R. Nissim, & L. Stott (Eds.), *Thinking psychologically about children who are looked after and adopted: Space for reflection* (pp. 164-194). Chichester: John Wiley..
- Duffy, B., Oyeboode, J. R., & Allen, J. (2009). Burnout among care staff for older adults with dementia: The role of reciprocity, self-efficacy and organizational factors. *Dementia*, 8 (4), 515-541. doi: 10.1177/1471301209350285

- James, I.A. (2011). *Understanding challenging behaviour in dementia that challenges: A guide to assessment & treatment*. London: Jessica Kingsley.
- King, J.M. (2014). *Evaluating psychological consultation in a specialist child and adolescent mental health service for looked-after and adopted children*. (Unpublished service evaluation submitted in partial fulfillment of the Doctorate in Clinical Psychology). Staffordshire & Keele Universities, Staffordshire.
- Luff, R., Ferreira, Z., & Meyer, J. (2011). *Care homes*. Retrieved from <http://sscr.nihr.ac.uk/PDF/MR/MR8.pdf>
- Roth, A. D., & Pilling, S. (2007). *The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders*. London: Department of Health.
- Schön, D. A. (1983). *The reflective practitioner*. New York, NY: Basic Books.
- Watts, S., & Stenner, P. (2012). *Doing Q methodological research: Theory, method & interpretation*. London: SAGE.
- Wilkinson, J. (1999). Implementing reflective practice. *Nursing Standard*, 13 (21), 36-40.
- Young, J.E., Klosko, J.S., & Weishaar, M.E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford.

## **Other: Additional Appendices**

## **Appendix W**

### **Author Submission Guidelines – *British Journal of Psychology***

The Editorial Board of the British Journal of Psychology is prepared to consider for publication:

- (a) reports of empirical studies likely to further our understanding of psychology
  - (b) critical reviews of the literature
  - (c) theoretical contributions
- Papers will be evaluated by the Editorial Board and referees in terms of scientific merit, readability, and interest to a general readership. All papers published in The British Journal of Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

#### **1. Circulation**

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

#### **2. Length**

Papers should normally be no more than 8000 words (excluding the abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

#### **3. Submission and reviewing**

All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the terms and conditions of submission and the declaration of competing interests. You may also like to use the Submission Checklist to help you prepare your paper.

#### **4. Manuscript requirements**

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from [here](#).
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution



of digital images must be at least 300 dpi. All figures must be mentioned in the text.

- All articles should be preceded by an Abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

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The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be

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## **Appendix X**

### **Author Submission Guidelines – *Dementia: The International Journal of Social Research & Practice***

*Dementia* publishes original research or original contributions to the existing literature on social research and dementia. The journal acts as a major forum for social research of direct relevance to improving the quality of life and quality of care for people with dementia and their families.

#### **1. Peer review policy**

*Dementia* operates a strictly anonymous peer review process in which the reviewer's name is withheld from the author and, the author's name from the reviewer. Each manuscript is reviewed by at least two referees. All manuscripts are reviewed as rapidly as possible.

As part of the submission process you will be asked to provide the names of peers who could be called upon to review your manuscript. Recommended reviewers should be experts in their fields and should be able to provide an objective assessment of the manuscript. Please be aware of any conflicts of interest when recommending reviewers. Examples of conflicts of interest include (but are not limited to) the below:

- The reviewer should have no prior knowledge of your submission
- The reviewer should not have recently collaborated with any of the authors
- Reviewer nominees from the same institution as any of the authors are not permitted

Please note that the Editors are not obliged to invite any recommended/opposed reviewers to assess your manuscript.

#### **1.1 Authorship**

All parties who have made a substantive contribution to the article should be listed as authors. Principal authorship, authorship order, and other publication credits should be based on the relative scientific or professional contributions of the individuals involved, regardless of their status. A student is usually listed as principal author on any multiple-authored publication that substantially derives from the student's dissertation or thesis.

#### **2. Article types**

*Dementia* welcomes original research or original contributions to the existing literature on social research and dementia.

*Dementia* also welcomes papers on various aspects of innovative practice in dementia care. Submissions for this part of the journal should be between 750-1500 words.

The journal also publishes book reviews.

#### **3. How to submit your manuscript**

Before submitting your manuscript, please ensure you carefully read and adhere to all the guidelines and instructions to authors provided below. Manuscripts not conforming to these guidelines may be returned.

*Dementia* is hosted on SAGE track a web based online submission and peer

review system powered by ScholarOne<sup>®</sup> Manuscripts. Please read the Manuscript Submission guidelines below, and then simply visit <http://mc.manuscriptcentral.com/dementia> to login and submit your article online.

IMPORTANT: If you are a new user, you will first need to create an account. Submissions should be made by logging in and selecting the Author Center and the 'Click here to Submit a New Manuscript' option. Follow the instructions on each page, clicking the 'Next' button on each screen to save your work and advance to the next screen. If at any stage you have any questions or require the user guide, please use the '**Online Help**' button at the top right of every screen.

All original papers must be submitted via the online system. If you would like to discuss your paper prior to submission, please refer to the contact details below.

**Innovative Practice** papers must be submitted via the online system. If you would like to discuss your paper prior to submission, please email Jo Moriarty [jo.moriarty@kcl.ac.uk](mailto:jo.moriarty@kcl.ac.uk).

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Submitted manuscripts should be arranged according to the "Uniform Requirements for Manuscripts Submitted to Biomedical Journals". The full document is available at <http://icmje.org>. When submitting a paper, the author should always make a full statement to the Editor about all submissions and previous reports that might be regarded as redundant or duplicate publication of the same or very similar work.

Ethical considerations: All research on human subjects must have been approved by the appropriate research body in accordance with national requirements and must conform to the principles embodied in the Declaration of Helsinki (<http://www.wma.net>) as well as to the International Ethical Guidelines for Biomedical Research Involving Human Subjects and the International Guidelines for Ethical Review for Epidemiological Studies (<http://www.cioms.ch>). An appropriate statement about ethical considerations, if applicable, should be included in the methods section of the paper.

### **6.2 Ethics**

When reporting experiments on human subjects, indicate whether the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional or regional) or with the Declaration of Helsinki 1975, revised Hong Kong 1989. Do not use patients' names, initials or hospital numbers, especially in illustrative material. When reporting experiments on animals, indicate which guideline/law on the care and use of laboratory animals was followed.

## 7. Acknowledgements

Any acknowledgements should appear first at the end of your article prior to your Declaration of Conflicting Interests (if applicable), any notes and your References. All contributors who do not meet the criteria for authorship should be listed in an 'Acknowledgements' section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, or a department chair who provided only general support. Authors should disclose whether they had any writing assistance and identify the entity that paid for this assistance.

### 7.1 Funding Acknowledgement

To comply with the guidance for Research Funders, Authors and Publishers issued by the Research Information Network (RIN), *Dementia* additionally requires all Authors to acknowledge their funding in a consistent fashion under a separate heading. Please visit [Funding Acknowledgement](#) on the SAGE Journal Author Gateway for funding acknowledgement guidelines.

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## 9. Manuscript style

### 9.1 File types

Only electronic files conforming to the journal's guidelines will be accepted. Preferred formats for the text and tables of your manuscript are Word DOC, DOCX, RTF, XLS. LaTeX files are also accepted. Please also refer to additional guideline on submitting artwork [and supplemental files] below.

### 9.2 Journal Style

*Dementia* conforms to the SAGE house style. [Click here](#) to review guidelines on SAGE UK House Style.

Lengthy quotations (over 40 words) should be displayed and indented in the text. *Language and terminology.* Jargon or unnecessary technical language should be avoided, as should the use of abbreviations (such as coded names for conditions). Please avoid the use of nouns as verbs (e.g. to access), and the use of adjectives as nouns (e.g. dements). Language that might be deemed sexist or racist should not be used. *Abbreviations.* As far as possible, please avoid the use of initials, except for terms in common use. Please provide a list, in alphabetical order, of abbreviations used, and spell them out (with the abbreviations in brackets) the first time they are mentioned in the text.

### 9.3 Reference Style

*Dementia* adheres to the APA reference style. [Click here](#) to review the guidelines on APA to ensure your manuscript conforms to this reference style.

### 9.4. Manuscript Preparation

The text should be double-spaced throughout with generous left and right-hand margins. Brief articles should be up to 3000 words and more substantial articles between 5000 and 6000 words (references are not included in this word limit). At their discretion, the Editors will also consider articles of greater length. Innovative practice papers should be between 750-1500 words.

#### **9.4.1 Keywords and Abstracts: Helping readers find your article online**

The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE's Journal Author Gateway Guidelines on [How to Help Readers Find Your Article Online](#). The abstract should be 100-150 words, and up to five keywords should be supplied in alphabetical order.

#### **9.4.2 Corresponding Author Contact details**

Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.

#### **9.4.3 Guidelines for submitting artwork, figures and other graphics**

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#### **10.4 OnlineFirst Publication**

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#### **11. Further information**

Any correspondence, queries or additional requests for information on the Manuscript Submission process should be sent to the Editorial Office at [dem.pra@sagepub.com](mailto:dem.pra@sagepub.com).

## Appendix Y

Email communication with the Co-editor of *Dementia* confirming extended word count for the research report (Chapter 2).

**From:** Phyllis Harris <pharris@jcu.edu>  
**Subject:** **Dementia Journal**  
**Date:** 28 September 2015 14:21:30 GMT+01:00  
**To:** Jordan King  
**Cc:** John Keady <John.Keady@manchester.ac.uk>

---

Jordan:

Yes; the topic would be of interest to the *Dementia* Journal. The word limit is 8,000.

Phyllis Braudy Harris, Ph.D.  
Professor and Chair, Department of Sociology & Criminology  
Director of Aging Studies  
Co-editor, *Dementia: The International Journal of Social Research and Practice*  
John Carroll University  
1 John Carroll Boulevard  
University Heights, Ohio 44118  
Tel: 216-397-4634  
Fax: 216-397-4376

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**From:** Nainwal, Manish <Manish.Nainwal@sagepub.in>  
**Subject:** **RE: Query regarding manuscript submission**  
**Date:** 28 September 2015 09:49:48 GMT+01:00  
**To:** KING Jordan M <k030781c@student.staffs.ac.uk>

---

Dear Jordan,

Thank you for your query.

I have forwarded your email to the Journal Editor and will reply to you shortly once I hear from him.

Sincerely,  
Manish Nainwal  
*Dementia: the international journal of social research and practice*

SAGE - Celebrating 50 years

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**From:** KING Jordan M [mailto:k030781c@student.staffs.ac.uk]  
**Sent:** Friday, September 25, 2015 4:14 PM  
**To:** dem.pra  
**Subject:** Query regarding manuscript submission

Dear Editor,

At present I am prospectively seeking a journal for submitting an original research article.

I am undertaking a research study exploring the use and benefits of psychological consultation with residential staff teams caring for people with dementia, in partial fulfilment of my doctorate in clinical psychology.

Please could you indicate:

- i) Whether your journal would be interested in such an article?
- ii) What is your word limit for submitted manuscripts?

Many thanks and kind regards,

Jordan.

Jordan King  
Trainee Clinical Psychologist  
Staffordshire and Keele Universities' DCLinPsy Programme